Day Hospitals Australia

Submission on the

Public Consultation Paper – Private health insurance reforms – Second wave

(December 2020)

Submitted to: Department of Health
GPO Box 9848
CANBERRA ACT 2601
(By email to: phiconsultation@health.gov.au)

Formerly known as the Australian Day Hospital Association
ABN: 37 054 719 050

www.dayhospitalsaustralia.net.au phone. 1800 752 822 fax. 08 9304 7228 email.info@dayhospitalsaustralia.net.au
PO Box 1143, Joondalup DC, WA 6919

Contents

Introduction

Day Hospitals Australia as the peak industry body for the day hospital sector recognises the need for Private Health Insurance (PHI) reform and welcomes the Second Wave of PHI reforms recently announced, which will provide incentive for younger Australians to hold PHI as well as providing alternative treatment settings for rehabilitation and mental health services.

It is well recognised that there are significant private health insurance savings to be made by increasing patient volume in the standalone day hospital setting for elective surgical procedures as well as medical services such as chemotherapy, radiation oncology, renal dialysis, mental health and sleep studies.

Same day procedures have grown at a faster rate in the overnight private hospital sector compared with the day hospital sector. As day procedures performed in the overnight sector attract a significantly higher benefit from the PHIs, on average 30% higher, there are significant savings to be achieved in transferring day cases to the day hospital sector. The day hospital sector provides quality cost-effective care with patient satisfaction rates currently at 96.21% (QPS Benchmarking 2020 Report). The Private Health Insurers have a responsibility to explore and implement strategies that will encourage the treatment of day patients in the day hospital sector, which in turn will assist in keeping premiums levels down.

Day Hospitals Australia appreciates the opportunity to provide comment on the Public consultation paper: *Private health insurance reforms – Second Wave (December 2020).*

Consultation 1: Increasing the age of dependents to encourage younger people and also people with a disability to maintain private health insurance

Day Hospitals Australia sees further expansion of voluntary aged-based discounts for private health insurance as a positive initiative to encourage more younger Australians to take up private health insurance in the future.

The day hospital environment is an appropriate setting for many surgical and medical treatments required by younger Australians, such as orthopaedics due to sporting injuries, oral surgery - for example wisdom teeth extraction, ophthalmic procedures - for example correction of strabismus (squint), mental health and oncology.

DoH QUESTIONS FOR ALL STAKEHOLDERS: DEPENDENTS

1. Should the maximum age for child dependents be 31 or when LHC typically applies (i.e., 1 July following an individual's 31st birthday)?

    a) To ensure a smooth transition we would support when LHC typically applies, that is 1 July following an individual's 31st birthday.

2. Should eligibility of a dependent continue to be limited to people without a partner?

    a) We agree with the current eligibility and see no advantage in covering a dependent's partner which would only increase private health insurance costs overall.

3. Should the age ranges of different categories of child dependents be standardised for all private health insurers?

a) Yes definitely. The system needs to be simple for consumers to understand.

4. Should the conditions of dependence for the different categories of child dependents be standardised for all private health insurers?

a) Yes definitely. The system needs to be simple for consumers to understand.

5. Should the definition of 'dependent child' be simplified?

a) Yes. The definition should reflect a son or daughter of any age between 0 and 31 years who requires financial support from their parent(s).

6. What purpose does the distinction between non-student and student dependents serve and should this be retained?

a) No. Both categories should fall under the dependent child definition as listed above in 5(a).

7. Should the current 10 insured groups be rationalised by removing groups not being used by insurers?

a) There should be some rationalisation to simplify understanding of the insurance groups and the following are suggested:
   i. Single – only one person
   ii. Couple – only 2 adults
   iii. Children only – 2 or more, none of whom is an adult
   iv. Single parent – 2 or more, only one of which is an adult (covers non-student)
   v. Family – 3 or more, only 2 of whom are adults (covers non-student)

8. What is the preferred criteria and mechanism for determining eligibility of people with a disability?

a) A disability should be a formally diagnosed condition documented in a formal report by a General Practitioner or Medical Specialist, and in the case of mental health a Medical Practitioner or Clinical Psychologist.

a)

9. Should there be standardised arrangements for determining eligibility of people with a disability, or is it preferable to allow each insurer to determine its eligibility criteria?

b) Yes, there should be standardised arrangements for determining eligibility of people with a disability as defined above in 8(a).

c) Private Health Insurers are not qualified to determine whether a person's disability is legitimate, this must always be the decision of a Medical Practitioner, or in the case of mental health a Medical Practitioner or Clinical Psychologist.

10. Should eligibility of a dependent with a disability be limited to people without a partner?

a) Yes.

11. What are appropriate metrics for measuring the impact of this proposal?

a) Demographics related to people aged between 24 and 31 still living at home and dependent financially would need to be examined to assess the cost implications should these dependents require health care using private health insurance. ABS data may be useful in assessing this impact.

12. What is the regulatory burden associated with this proposal?

a) No increase in the regulation of the PHI Act due to this reform is anticipated.

Consultation 2: Expanding home and community based rehabilitation care

It is understood that the primary focus of this reform is to expand home and community-based rehabilitation in orthopaedics, as indicated at the Private Health Insurance Consultation meeting on 28 January 2020 and accordingly our response has focused on this specialty.

The day hospital sector is an appropriate lower cost setting for many orthopaedic procedures requiring post-operative rehabilitation. Day Hospitals Australia supports models of care that combine short stay arthroplasty and home or community-based rehabilitation, bringing Australia into line with international trends which will be particularly relevant in this COVID-19 era.

Joint arthroplasties are safe in the day hospital setting. In a recent study by Bosco et al (http://pubmed.ncbi.nlm.nih.gov/28870744/) found 70.3% of patients were eligible to have their total hip or knee replacement in an ambulatory surgery center (stand-alone day hospital).

Short stay arthroplasty in the day hospital setting must be clinician led. Recent developments in Australia, including the Perioperative Medicine Steering Committee which reports to ANZCA, will be beneficial in supporting the care of surgical patients having such procedures in the day hospital setting.

It is important to recognise that vigorous medical assessment and optimization of the patient's medical health will be important to the expansion of orthopaedic surgery into the same day hospital setting. Moen et al in *Outpatient Total Joint Arthroplasty* (2017), (https://pubmed.ncbi.nlm.nih.gov/29064004/) stated:

> *"Between 2012 and 2015 in the US there was a 47% increase in outpatient total joint arthroplasty (day hospital) and a further 77% growth is expected in the 10 years from 2017". "In 2016 the mix between inpatient and ambulatory surgery center arthroplasty was 85%/15%. This is expected to shift to 68%/32% in 2020 and by 2026 the number of arthroplasties performed in the ambulatory surgery setting is expected to exceed inpatient arthroplasties by 51%/49%."*

Day Hospitals offer an innovative solution to change the paradigm for the treatment of arthroplasty in Australia. These proposed reforms to allow funding by private health insurers of home and community-based rehabilitation are a positive step towards a necessary shift in the way care is delivered in Australia.

Private Health Insurers will need to contract with both day hospitals providing orthopaedic services and rehabilitation providers to protect consumers from out-of-pocket expenses. Where a contract is not in place for these out of hospital rehabilitation services a default payment, similar to Second Tier Default, would need to be established to protect service providers and consumers.

QUESTIONS FOR ALL STAKEHOLDERS: REHABILITATION SERVICES

1. Which procedures and/or MBS item numbers should have a rehabilitation plan?

    a) Those orthopaedic procedures that require rehabilitation as advised by the patient's orthopaedic surgeon, such as joint arthroplasty, shoulder repair, etc.

2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

    a) The rehabilitation plan must be clinician driven and should involve the patient, the rehabilitation providers and the hospital to ensure a smooth execution of this plan.
    b) The necessity for a rehabilitation plan will be determined by the specialist surgeon with subsequent consultation with the patient, the rehabilitation providers and the hospital.
    c) There should be an exemption option if the patient is not prepared to undergo rehabilitation in either their home or the community, then compliance to the specialist plan is unlikely and would be detrimental to the patient's recovery.

3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

    a) The initial plan needs to be developed by the treating surgeon and clearly documented so that the patient, the hospital and the rehabilitation provider are clear on the plan objectives. Once the plan is initiated this should be a team approach with regular feedback to the treating surgeon on the progress of the patient and with any suggestions for adjustments that may be necessary. This information should be clearly documented in the patient record.
    b) A summary of the patient's rehabilitation plan should be provided to the patient's private health insurer, which could be done in conjunction with the discharge plan.

4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

    a) The plan should be provided to the patient, the discharging hospital and the rehabilitation provider.

5. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community-based rehabilitation services and oblige insurers to fund these services?

    a) It will be important to identify registered providers of home-based rehabilitation which may require specific application for approval to enable the private health insurer to fund this service.
    b) Community based rehabilitation is more than likely to have formal recognition through AHPRA with registered physiotherapists and occupational therapists.

6. What transition arrangements and timeframe would be appropriate to implement this reform?

a) In order to see the growth of orthopaedic surgery, including short stay arthroplasty in the day hospital sector, the transition will require support primarily from orthopaedic surgeons who must drive this change which will necessitate home or community-based rehabilitation services post discharge from a day hospital.
b) As well as post-operative rehabilitation to optimise the patient's recovery pre-habilitation, prior to surgery, will afford a quicker recovery post operatively. Consideration should be given to funding of pre-habilitation care as part of the whole approach to arthroplasty performed in the day hospital setting followed by home or community-based rehabilitation, which will be more cost effective than short stay arthroplasty in the overnight private hospital sector.
c) The timeframe will be dependent on all stakeholders involved in same day arthroplasty, that is orthopaedic surgeons, day hospitals and rehabilitation providers working together to change the current model of care. The acceptance by consumers/prospective patients of the new options for rehabilitation post-procedure will be crucial to its success.

7. What are appropriate metrics for measuring the impact of this proposal?

a) The increased percentage of patients opting for home or community-based rehabilitation.
b) An increase in the number of arthroplasties performed in the day hospital sector.

8. What is the regulatory burden associated with this proposal?

a) As there are already in the home and community-based rehabilitation services available then this would be seen as an opportunity to grow this service.
b) There should be a requirement to formally register both home and community-based providers.

9. Service providers: what services would you deliver under this proposal?

a) As previously mentioned above, the day hospital sector needs to grow in Australia to accommodate orthopaedic surgery including total joint replacement.
b) There have already been services established in this area in some parts of Australia.

Consultation 3: Out of hospital mental health services

The day hospital sector provides another option for patients requiring mental health services as opposed to admission to a large overnight facility. The day hospital setting provides a non-institutional environment which allows treatment on a daily basis with the patient still having close contact with family and friends during this process, due to the ability to attend on a daily basis only, as opposed to spending extended time away from family in an overnight facility.

Day Hospitals Australia has received feedback from members providing mental health services in the day hospital setting who have reported the following:

a) *"Multiple examples of insurers stating and insisting that mental health is defined as an inpatient service only, or is an outpatient service covered by MBS, and refusing their members access to our day hospital service."* This is a concern for Day Hospitals Australia as day hospitals patients are admitted patients in accordance with the PHI legislation.

b) *"The appropriate amount of therapy that patients receive will be a minimum of three hours per day for patients who have the capacity to tolerate this amount of therapy. This should occur on a minimum of five days per week." We have multiple examples of insurers stating the requirement is 4.5 hours per day.* Day Hospitals Australia would expect that the treatment time would be directed by the psychiatrist or clinical psychologist providing the care and in the best interests of the patient, and not dictated by private health insurers.

c) *"The definition of an admission could benefit from clarification in legislation so that it is also suitable for mental health day admission."* Day Hospitals Australia understands under the legislation that day hospitals that have been classified as hospitals by the Commonwealth Department of Health provide admitted services to their patients. Patients receiving services from day hospitals are admitted and not classified as outpatients.

QUESTIONS FOR ALL STAKEHOLDERS: MENTAL HEALTH SERVICES

1. What additional mental health services funded by insurers under this proposal would be of value to consumers?

a) Preventative mental health services to include patients who are starting to become unwell, but their symptoms are not severe enough to require hospital admission at that stage. Their condition may well deteriorate without support.
b) Follow up care out of hospital – intensive outreach or hospital in the home – transitional care as part of discharge planning. The patient may well remain fragile and require ongoing care to prevent readmission.
c) Patient and carer / family engagement in the form of family meetings following discharge to enhance positive outcomes.
d) Funding for use of technology, such as Telehealth and appropriate Apps, that are prescribed by the Psychiatrist / treating team.
e) Funding for psychoeducation for family/carers can improve their capacity to support mental health patients. The context of family can have a significant impact on trajectory and recovery of mental health patients.

2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?

a) Yes, however some thought needs to be given to the assessment process and key indicators for patient inclusion. The definition of a mental health condition should be a formally recognised psychiatric disorder or mental health condition accepted by RANZCP as a recognised mental health condition and the diagnosis should only be provided by a GP, Psychiatrist or Clinical Psychologist. This diagnosis should be a documented report with evidence and rationale of the condition and not in the form of an opinion in a letter.
b) This would require a standardised approach to the assessment as to not exclude a patient on the basis of a pending diagnosis.
c) Currently NDIS/NDIA use a report-based process with medical evidence to substantiate eligibility for private health insurance cover in Australia.

3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

a) Yes, without question, there must be an accreditation process for professionals to participate. That said, we do not need to reinvent the wheel, and this should be an add on to the existing process of accreditation within the national mental health standards for existing providers.

b) Practitioners should only include AHPRA registered practitioners, so that insurers and the public can rely on the existing regulator for confirmation of status, and this can be readily checked on the register.

4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?

a) Robust process for funded assessment – similar to the approach currently in place via NDIS.
b) Review via MDT / case conference, including the formulation of a documents care plan.

5. Are there any mental health services insurers should not be permitted to fund?

a) Yes. Consultation or mental health services provided to individuals who do not have a psychiatric disorder or a documented and recognised mental health condition, who have **not** received a formal diagnosis from a GP with mental health training, psychiatrist, or clinical psychologist.
b) Consultation or mental health services provided to individuals who are assessed by GP with mental health training, psychiatrist, or clinical psychologist as **not** presenting with clinical need, risk or severity that warrants a day admission or inpatient admission.

6. How should the relevant patient cohort be identified as eligible for services?

a) Formally diagnosed psychiatric disorder or other mental health condition accepted by the RANZCP as recognised mental health condition**, and** the diagnosis should be only provided by a GP, psychiatrist, or clinical psychologist only, in the form of a documented Report with evidence and rationale for the condition documented, so it can be placed on file. This should not be in the form of an opinion, in a letter, as is commonly done.
b) There must be a process of MDT / case conference to formulate the best possible care plan based on the individual needs.
c) Must have an actual assessment, not a recommendation via a health fund.

7. Who should identify relevant patient cohorts, and should insurers set criteria for which members would be eligible?

a) The patient cohort should be defined as patients with a formally diagnosed psychiatric disorder or other mental health condition accepted by the RANZCP as recognised mental health condition**,** and the diagnosis should be only provided by a GP, psychiatrist, or clinical psychologist only.
b) There must be an agreed selection criteria or eligibility criteria for access to services. The role of the referring doctor or health professional should be respected, and their responsibility for care of their patient supported, and not by passed or superseded by an insurance fund.
c) This must be a uniformed approach, in that there should not be a different set of rules from health fund to health fund – the same access for all patients?

8. What are appropriate metrics for measuring the impact of this proposal?

a) Consumer rating similar to PEX and / or HoNOS ratings.
b) Use of a standardised rating scale that is already in use (is DASS).
c) Usage v cost compared to lifetime cost of member. Consumer satisfaction of offering.

9. What is the regulatory burden associated with this proposal?

a) This has already been explored by the Improved models of care working group. There appears to be no real regulatory burden, however there must be a higher level of participation by health funds to provide a willingness to participate.

10. Service providers: what services would you deliver under this proposal?

a) Expanded and detailed community care delivery, i.e., hospital in the home and intensive outreach services that is more than the current offering by some funds.
b) Evidenced based mental health care for specific disorders and presentations , that are more intensive than outpatient services (which are typically only 1 hour duration, once per month up to once per week, and are not enough for chronic mental health patients).
c) Psychoeducation and support for family and carers, to improve their capacity to support the patient.

Consultation 4: Applying greater rigour to certification for hospital admission

Day Hospitals Australia was concerned with the reference to certification for hospital admission in relation to Type C procedures, however during a meeting with Alistair Wilson, Department of Health, on 20 January 2021 with our CEO, Jane Griffiths, clarification was provided by Alistair in relation to the certification concerns. It is understood that the issues with certifications in the main apply to patients admitted for medical tests, particularly elderly patients and patients admitted for allergy testing assessment where they are hospitalised either on a day or overnight basis.

Previously, there were issues around surgical Type C procedures requiring admission for various reasons which were being rejected by some private health insurers. Therefore in 2017 Day Hospitals Australia and the Federal AMA worked with the Department of Health to develop the Clarification of Roles in the Certification Process PHI 37/17 dated 19.07.2017 ***(see Attachment 1)*****.** Once this document was in place the number of rejections reduced, however members still reported some concerns in this area. As a consequence, guidelines were established for the admission of Type C patients to the day hospital sector and ratified by the College of Dermatology, the Society of Plastic Surgeons, the AMA, and General Surgeons Australia – ***see Attachment 2.***

QUESTIONS FOR ALL STAKEHOLDERS: CERTIFICATION FOR HOSPITAL ADMISSION

1. Should an industry mediation panel be established to resolve hospital certification disputes?

a) Possibly. However, the document states that the issues relating to inappropriate certification of Type B and Type C procedures is by a **small** number of providers. As this appears to be more related to medical admissions rather than surgical admissions, perhaps there could be some medical guidelines established by the Royal College of General Practitioners, the Royal College of Physicians and the AMA to provide guidance to doctors wanting to admit medical patients where the classification is Type B in the case of overnight facilities, and Type C in the case of day hospital services.

2. If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?

   a) The development of a mediation panel should be discussed with the relevant medical colleges, impacted by inappropriate certification.

3. What parties should be involved in the development of advice on the appropriate criteria for certification?

   a) Royal College of General Practitioners, the Royal College of Physicians and the AMA.
   b) Surgical guidelines have already been established as mentioned above ***(Attachment 2***).

4. Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?

   a) Only in the case of continued repeated incidents by the same practitioner should the matter be referred to PSR for further investigation.

5. Should there be a specified list of 'special circumstances' allowable for Type C certificates?

   a) Yes. For Type C patients requiring admission to a day hospital and ratified by the College of Dermatology, the Society of Plastic Surgeons, the AMA, and General Surgeons Australia – ***see Attachment 2.***
   b) Recommend the establishment of medical guidelines by the Royal College of General Practitioners, the Royal College of Physicians and the AMA.

6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

   a) No. This is the treating doctor's responsibility.
   b) There are circumstances, particularly in relation to the surgical removal of skin lesions where the type of procedure, that is Type B or C, will not be known until the pathology test result is provided, at which time the patient will have been discharged from hospital. Under these circumstances it is difficult for the hospital to provide informed financial consent when the procedure type is not confirmed, so often patients will be charged on admission, and once the pathology is identified and it is possible to claim the procedure under their private health insurance the patient can then submit their account for benefit to their private health insurer.

7. What is the likely impact upon premiums of this proposal?

   a) It is unlikely that there will be an impact on premiums.

8. What is the likely impact on the number of people and/or policies covered of this proposal?

   a) This will depend on the patient's level of insurance and the nature of the procedure.

9. What are appropriate metrics for measuring the impact of this proposal?

   a) The number of circumstances where the appropriate guidelines have not been met.

10. What is the regulatory burden associated with this proposal?

a) As this is a very small matter, as identified in the Consultation Paper, there should be little or no impact.

11. Are there any other reform options that should be considered?

a) Private Health Insurers need to respect the treating medical practitioner's criteria in the certification document as outlined in ***Attachment 1,*** and in accordance with the established guidelines in ***Attachment 2***, and the proposed guidelines for medical patients as suggested by Day Hospitals Australia.

Conclusion

Day Hospitals Australia in principle is supportive of the Second Wave of Private Health Insurance Reforms and is keen to assist the Government and the Department with the implementation of these reforms.

The feedback that we have provided in this document we trust will assist in refining the details of the various reforms. For the Day Hospital sector these are significant reforms, which enhance the services provided by day hospitals and will assist in providing Australian consumers with further options for the delivery of services they may require.

Day Hospitals Australia would be pleased to provide any additional information required to support this submission.

Should you wish to discuss any of the above in more detail, please do not hesitate to contact me directly on 08 9332 3606 or jane.griffiths@dayhospitalsaustralia.net.au.

Jane Griffiths
Chief Executive Officer

4 February 2021

Australian Government
Department of Health

Private Health Insurance Circular

Private Health Insurance Branch
Pharmaceutical Benefits Division
MDP 853
GPO Box 9848
CANBERRA ACT 2601

PHI 37/17
19 July 2017

CLARIFICATION OF ROLES IN THE CERTIFICATION PROCESS

The Department has been made aware of systemic issues relating to the certification of Type B and C procedures. The issues are:

1. Confusion and lack of awareness of certification requirements resulting in a lack of detail or incorrect information provided by hospitals and medical practitioners to insurers; and
2. rejection of the medical conditions or special circumstances outlined in the certification documentation based on medical assessment by insurers.

The requirements for certification are set out in Schedule 1 Part 3 Sections 10 and 11 and Schedule 3 Part 2 Section 7 of the *Private Health Insurance (Benefits Requirements) Rules 2011* (the Rules).

While there is no specified format for the certification documentation in order to meet the certification requirements it should include at a minimum:

- sufficient information to identify the patient, the certifying medical practitioner and the specific medical procedure being certified;
- details of the patient's medical condition, or the special circumstances relevant to the specific procedure, that the medical practitioner is certifying require it to be performed in a hospital; and
- a signed statement with wording to the effect that the medical practitioner certifies that it would be contrary to accepted medical practice to provide the procedure unless the patient is given hospital treatment that either includes (if certifying as Type B) or does not include (if certifying as Type C) part of an overnight stay.

Role of insurers

Insurers have an obligation to check the validity of certification documentation to ensure it meets the requirements as set out in the Rules and the procedure is covered by the patient's private health insurance policy including checking pre-existing conditions, exclusions and waiting periods. However insurers should be aware that the Rules do not provide for any clinical assessment by insurers of the medical conditions/special circumstances certified by a medical practitioner.

Any insurer that rejects certification for any reason other than that they fail to meet the requirements prescribed in the Rules or that the proposed procedure is not covered by the patient's health insurance policy is in breach of the Rules.

- If there is insufficient or incorrect information in the certification to meet the requirements of the Rules or to determine if the procedure is covered by the patient's policy, insurers should in the first instance, work with the hospital or medical practitioner providing the certification documents to seek further information.
- Should insurers reject a medical procedure provided in a hospital setting that a patient believes is covered by their health insurance policy or there are unexpected out-of-pocket costs, patients can refer the matter to the Private Health Insurance Ombudsman (PHIO) for further investigation on 1300 362 072 or at phio.info@ombudsman.gov.au.

Role of medical practitioners/hospitals

Medical practitioners have an obligation to ensure they complete the certification documentation consistent with the requirements as set out in the Rules particularly they must specify either the:

- medical condition of the patient (for example Haemophilia or for more complex cases provide more detail); or
- special circumstances (for example a medical procedure on a young child or requirement for provision of general anaesthesia)

that, contrary to accepted medical practice, require the procedure to be conducted in hospital.

Certification documentation completed by a medical practitioner may be used by PHIO to assist in assessing whether, contrary to accepted medical practice, a medical procedure requires hospital treatment.

Examples of information that does not meet this requirement are shown below:

- descriptions of the procedures performed (e.g. the MBS item description);
- generic circumstances that are not specific to either the patient or the particular procedure (e.g. need to use sterile instruments, setting for patient safety and monitoring patient for adverse reactions); and
- lack of equipment that might reasonably be expected to be provided in a medical practitioner's consulting room (however the specific circumstances need to be taken into consideration, for example in rural/remote areas where no specialist consulting rooms are available, a hospital may be the only location with the necessary equipment).

Criteria for Type C Banding Certification
A GUIDE FOR MEDICAL PRACTITIONERS

In accordance with the *Private Health Insurance Act 2007* and *Private Health Insurance (Benefit Requirements) Rules 2011*, Type C procedures do not normally require hospital treatment. However, under certain situations minimum private health insurance benefits are payable for patients admitted to hospital to receive a certified Type C procedure. For benefits to be payable, the medical practitioner providing the procedure must certify in writing that it would be contrary to accepted medical practice to provide the procedure unless the patient is given hospital treatment because of: a) the patient's medical condition; or b) other special circumstances.

To assist medical practitioners to complete Type C Banding Certification for private health insurance claims, the following criteria for Type C Banding Certification Form (the Form) have been developed and endorsed by the Australian Society of Plastic Surgeons, the Australasian College of Dermatologists, General Surgeons Australia and the Australian Medical Association.

In completing the Certification, medical practitioners can in short-hand refer to criteria from the general (i.e. 1a) or specific (i.e. 2a; 3a; 4a) categories as listed in the Form. If Certification is otherwise correctly completed and signed, the Private Health Insurer is expected to accept the Certification.

Criteria for Type C Banding Certification

1. General category

a) Tertiary referrals from dermatologist to surgeon

b) Any chronic medical condition requiring specialist or physician supervision including but not limited to: hypertension; morbid obesity; renal failure; liver failure; diabetes; asthma / emphysema; peripheral vascular disease; epilepsy; coronary artery disease; anaemia; metastatic malignancy; myaesthenia gravis; dementia; movement disorders; or bleeding diathesis

c) Patients with high fall risk or physical / mobility impairment requiring specialised handling or transfer equipment

d) History of anaphylaxis or allergy to latex or local anaesthetic

e) Infected lesions

f) Bleeding risk as a result of a documented coagulopathy or as a consequence of blood thinning agents that cannot be safely stopped prior to surgery

g) Referred rural and remote patients (greater than 100 km travel for patient)

h) Referred rural and remote occasions of service (greater than 100 km travel for specialist)

i) Patients under 16 years and over 75 years or not mentally competent to give consent

j) Needle phobic patients

k) Patients with a history of vasovagal faints

l) Multiple lesions (3 or more) to be treated at the same episode

Specific Medicare Benefit Schedule (MBS) items

2. MBS Item 31365

Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if:

a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and

b) the necessary excision diameter is less than 15 mm; and

c) the excised specimen is sent for histological examination; and

d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201

a) Malignancy greater than 5 mm diameter
b) Recurrent malignancy
c) Invasive malignancy (i.e. not intraepithelial carcinoma or superficial basal cell carcinoma [BCC] less than 5 mm)
d) Gorlins syndrome; familial keratoacanthomas; xeroderma pigmentosum; albinism; Fanconi's anaemia

3. MBS Item 31362

Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:

a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and

b) the necessary excision diameter is less than 14 mm; and

c) the excised specimen is sent for histological examination; not in association with item 45201

a) Dysplastic naevus syndrome or past history of melanoma or first degree relative with melanoma where reasonable suspicion of malignancy exists
b) Dysplastic naevus with severe atypia on histology
c) Scalp lesions (bleeding risk)
d) Keloid or hypertrophic scar risk (where there is a personal past history of true keloid or a first degree relative with true keloid formation)
e) Disfiguring lesion (photo)
f) Past history of this particular cyst being infected
g) Varicose veins or peripheral vascular disease when the lesion is at the knee or below
h) Trichoepithelioma greater than 5 mm (can be impossible to distinguish from BCC)

4. MBS Item 31357

Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:

a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and

b) the necessary excision diameter is less than 6 mm; and

c) the excised specimen is sent for histological examination; not in association with item 45201

a) Trichoepithelioma or similar lesion where malignancy is suspected
b) Nasal tip lesions

Endorsed by the Australian Society of Plastic Surgeons, the Australasian College of Dermatologists, General Surgeons Australia and the Australian Medical Association; June 2018