Optometry Australia submission to the Medicare Benefits Schedule Review Taskforce's Public Consultation

Optometry Australia welcomes the opportunity to input to the Medicare Benefits Schedule Review Taskforce's public consultation. Optometry Australia is the peak professional body for optometrists, representing around 90% of all optometrists registered in Australia. The following submission provides a:

- brief overview of ocular disease and vision loss in Australia and the role of optometry in minimising this;
- an overview of the scope of optometric practice and Medicare coverage of optometric services
- detailed responses to the questions posed by the Taskforce through the consultation.

Optometry Australia would welcome the opportunity to discuss issues raised herewith further, and to provide further evidence, as may be required, to support points made below.

Background

Impacts of ocular disease and vision loss

The prevalence of many ocular diseases increases exponentially with age and the rate of vision loss trebles for each additional decade after 40 years.[1] In 2009 there were an estimated 575,000 Australians over the age of 40 with some form of vision impairment or blindness. This is expected to increase to over 800,000 by 2020. Given 75% of all vision loss and blindness is avoidable or treatable with early intervention, timely access to primary eye care has proven vital in reducing the heavy social and economic costs associated with avoidable blindness and vision loss, and preventing or slowing the development of ocular and systemic conditions that can require costly specialist care.

As the World Health Organisation has noted, "visual impairment, including blindness, has significant human and socioeconomic consequences in all societies; the costs of lost productivity and of rehabilitation and education of the blind represent significant economic burdens for the individual, the family and society."[2] In Australia, estimates suggest that the health and social costs associated with vision disorders are around $9.85 billion per annum.[3] A key element here is reduced productivity as a result of vision loss.

[1] Access Economics. (2004.) Clear Insight: The Economic Impact and Cost of Vision Loss in Australia. Commissioned by The Centre for Eye Research Australia.

[2] World Health Organization. Morone P, Cuena EC, Kocur I, Banatvala N. (2012) Investing in eye health: securing the support of decision-makers. Accessed 24/06/2015 via: www.who.int/blindness/Politicalanalysis.pdf

[3] Australian Government Department of Health (2015.)Implementation plan under the National framework for action to promote eye health and prevent avoidable blindness and vision loss. Accessed 24/06/2015 via: www.health.gov.au/internet/main/publishing.nsf/Content/eyehealth-pubs-impl

Notably, the cost to the Australian Government for all services provided by optometrists under Medicare in 2014 was $399,769,949 and there is evidence that annual investment will reduce following the reduction of the patient rebate for all optometry services from 1 January 2015. Optometry, by playing a pivotal role in the detection and management of sight-threatening conditions and by correcting refractive error and restoring vision, plays a broader economic role in assisting a person to remain in the workforce. This role extends into assisting the enormous number of people who undertake voluntary work in the Australian community. It is estimated that approximately 43% of those aged between 45 and 64 years undertake voluntary work, as do 31% of those aged 65 and over. If the voluntary work undertaken requires good near vision, optometrists are well placed to assist as nearly all people over the age of 45 are likely to benefit from receiving a near vision correction.

Optometric practice in Australia and Medicare

The optometry profession consists of a workforce of approximately 4,900 nationally registered optometrists. As the cornerstone of eye care in Australia, optometry plays a key role in the prevention, early detection and management of eye and vision disease, which includes systemic disease with ocular and/or visual manifestations. Optometrists provide the majority of primary eye care in Australia. For many, an optometric eye examination is their entry point into the primary health care system as those who avoid other forms of health care tend to seek optometric care due to the significant impact poor sight has on their daily life.

Optometrists employ a broad scope of practice encompassing:

- diagnosis and management of uncorrected refractive error, the common vision condition readily correctable with prescription lenses;
- detection of various chronic conditions including diabetic retinopathy (estimated to impact more than 1 million Australians)[4], glaucoma (estimated to impact 300,000 Australians)[5], macular degeneration and cataract. Early detection of many of these conditions, enabled through regular and timely access to a comprehensive eye examination by an optometrist, can significantly alter patient health outcomes, preventing or slowing the progression of vision loss and the onset of blindness;
- management of chronic eye conditions, including through partnership with ophthalmologists and general practitioners (GPs) and referral of patients to tertiary care when clinically necessary;
- detection of common eye complaints such as dry eye and conjunctivitis, and management of these conditions, which is often through the use of topical eye drops; and
- management of uncomplicated emergency conditions such as removal of an ocular foreign body.

Led by Optometry Australia, the optometry profession continues to evolve and expand, 40% of optometrists are now able to prescribe topical ophthalmic therapeutic agents for the treatment of the eye, including antibiotic, antiviral, anti-inflammatory and anti-glaucoma medication. This

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[4] Baker IDI and the Centre for Eye Research Australia.(2013) Out of Sight. A report into diabetic eye disease in Australia.

[5] Victorian Government, Better Health Channel. (2012) Eyes – Glaucoma, fact sheet. Developed by the Centre for Eye Research Australia.

supports early intervention and management, resulting in a decrease in permanent vision loss and blindness. PBS listing has been secured for the majority of these agents.

Optometrists deliver eye care predominately in community-based practices, as well as other settings which facilitate access for patients with high prevalence of chronic eye and vision conditions, including visiting outreach programs in remote and very remote areas, Aboriginal Medical Services and in domiciliary settings such as residential aged care facilities

In 1975, Optometry was included in Medicare to enable patients in Australia to access affordable primary eye health and vision care. At the time, four item numbers were available to bill for varying professional attendances including comprehensive eye examinations and fitting of contact lenses. In 2015, the Optometrical Services Schedule of the Medicare Benefits Schedule (OMBS) lists 32 items, enabling patients to access a rebate for a range of different consultation services.

The current OMBS provides patients with access to comprehensive eye examinations and recognises the increasing scope of practice that optometrists work within. For example, item 10913 of the OMBS provides patients with a rebate and provides access to an eye care professional that can diagnose and manage new signs and symptoms that may present for acute or chronic conditions; item 10914 provides a patient rebate for an optometry consultation to assess and manage a progressive condition that requires regular and ongoing care and management; item 10915 allows for patients with diabetes to access appropriate eye care including a dilated fundus examination at clinically necessary intervals.

A range of items supports the fitting of contact lenses for a number of clinical presentations including the correction of ametropia, advanced corneal disease and/or other medical conditions as required. In 2015, five new items were introduced into the OMBS including the first procedure based item – item 10944 for the removal of an embedded corneal foreign body by an optometrist. Additionally, four items that provide a rebate for optometrists to accompany patients in accessing a ophthalmological consultation via telehealth, providing patients who are unable to access specialist care due to physical disability, remoteness or lack of service in their area, ready access to ophthalmological care.

Response to consultation questions

Q. Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

Optometry Australia believes it is appropriate to review the MBS to ensure the MBS continues to support contemporary best practice. Optometry Australia is best placed to comment with regard to the Optometrical Services Schedule (OMBS) which lists consultations and procedures provided by an optometrist that attract a patient rebate under Medicare. We believe that the items listed on the OMBS largely remain appropriate to contemporary practice, though there are opportunities for amendments to specific item descriptors to improve alignment with current best practice standards and recommendations for frequency of examination, as well as to improve clarity regarding when an item can or cannot be billed.

Whilst many of the items on the OMBS are long standing items, for many years Optometry Australia, as the peak professional body for the profession, has worked with the Department of Health and the Department of Human Services, as part of the Optometric Benefits Consultative Committee (OBCC) to amend OMBS item descriptors and associated guidelines to align with

developments in best practice eye care. Optometry Australia have identified additional minor amendments to OMBS item descriptors required to ensure they support contemporary best practice, which are currently under consideration by the OBCC or soon to be raised through this forum. A number of these issues are also outlined here.

Notably, scheduled fees, and hence the bulk-bill rate that is charged to patients who cannot afford an out-of-pocket expense is out-of-date, with respect to the true costs of providing clinical care.

Indexation of the OMBS has consistently not kept pace with the Consumer Price Index (CPI). Since the mid-1990s, indexation has been aligned to a specific wage cost index that does not reflect the true cost of providing clinical care, such as adopting and upgrading the necessary technology to improve patient outcomes. This means the amount optometrists are able to charge for their services has been decreasing year after year, in real terms. The estimate difference between the most commonly billed (at the time) optometry item under the OMBS (item 10900) was estimated to be close to $13 less than what it wold have been if CPI had been used as an indexation measure since 1997.

Since then, the Government has enacted an extended freeze on the OMBS; OMBS item fees have not been indexed since November 2012 and indexation is not expected until 1 July 2018. In addition, effective from 1 January 2015, the scheduled fees for all OMBS items were reduced by around five percent. There appears to be no precedent for this reduction and no evidence to indicate that it would not adversely affect patient access to care and the sustainability of vital eye care services. Surveys conducted by Optometry Australia show that patient access to recommended eye care, particularly for low income patients and those in socially disadvantaged areas is already being, is already reducing.

The cumulative impact of inadequate indexation, a lengthy freeze of indexation and the 5%rebate reduction, means that the gap between the scheduled fee and the true costs of providing clinical care continually increases, threatening the sustainability of the primary eye-care system.

Our estimates suggest that the cumulative effect of the 5% rebate reduction and indexation freeze will mean that patient rebates for optometric care, when averaged across OMBS consultation items, will be around $10 less from December 2014 to July 2018, than it would have been if the rebate rate was maintained and CPI applied.

Of particular note, with respect to the outdated nature of OMBS item fees, are items to support domiciliary visits (items 10931 to 10933.) These are items that can be billed in additional to a consultation item and which are intended to partially cover costs associated with travelling etc. to provide domiciliary services. These items provide a rebate of $23.30 per visit, regardless of how many patients were seen as part of the visit. Optometry Australia research shows that the total incurred cost (opportunity cost) to the optometrist to provide a domiciliary service at any one location is on average over $100. The discrepancy in the MBS fee and the cost of providing this service, particularly given that many of the patients accessing domiciliary services cannot afford out-of-pocket health care expenses, is an established disincentive to the provision of such care. Although it is difficult to accurately quantify the level of unmet patient need for domiciliary eye care due to a lack of available data, Optometry Australia often receives urgent inquiries from aged care facilities and family members seeking assistance to source an optometrist to provide primary eye care for their residents or relative. Unfortunately, not all these

inquiries are able to be resolved in a timely manner given the low number of optometrists who regularly provide domiciliary visits.

Q. Do you have any comments on the proposed MBS Review process?

Optometry Australia supports, in principle, the proposed review approach that draws together input from clinical committees, working groups and rapid reviews.

We look forward to further information of the piloting processes underway with several medical specialities.

We believe the focus on evidence via the rapid review process is appropriate, and that this needs to be balanced through strong guidance from professionals with expertise in the discipline who are well placed to comment on contemporary best practice and assure rapid review questions are appropriately targeted.

We strongly support the involvement of esteemed clinicians in the relevant profession, in our case, optometrists. We recognise the benefits of involving clinicians from related disciplines and generalists, however, also caution the necessity of ensuring that such professionals have a sound understanding of the scope of practice of the profession being reviewed.

We note that members of the clinical committees will be required to confirm that no real or perceived conflict of interest exists with regard to their role on the committee. We note that most optometrists well placed to participate in a clinical committee will provide Medicare services, and strongly suggest this is not regarded as a conflict of interest that would limit participation. Similarly, we note that many eminent and esteemed optometrists have strong links with Optometry Australia, the peak national representative for the profession. Whilst around 90% of registered optometrists in Australia are members of Optometry Australia, many of those with a particular passion for the profession or particular areas of practice, may also hold, or have previously held, advisory or governance roles, within Optometry Australia or its affiliates state organisations. Given this, we believe it would be inappropriate to exclude optometrists from membership of the clinical committee due to a current or previous role with the peak body.

With regard to the rapid review process, we note that many OMBS items support optometry *consultations* rather than the specific procedures or investigations. These items offer benefit to patients in relation to the prevention, diagnosis, management and treatment of a range of acute and chronic eye conditions.

Given this, there may be a different approach required to assess these items. We are interested in how similar items in the GP schedule will be assessed. We question whether the approach used in Ontario's Appropriateness Initiative may be readily applied to this context given the expected challenges of identifying a single targeted research question. We believe in such instances the rapid review process should be cautiously applied.

Q. How can the impact of the MBS Review be measured?

- What metrics and measurement approaches should be used?

- How should we seek to improve this measurement and monitoring capability over time?

Optometry Australia notes that the key objective of the review is to improve the value derived from the investment in Medicare services. We recognise that it is challenging to measure achievement against this objective in the short term, particularly if there is not a well-established

base line value, and hence support the suggestion of a focus on process review in the short term, with assessments linked to the number of reviews completed and the proportion of items reviewed.

We recommend additional process measures be included to also encourage a focus on quality reviews and strong consultation, and avoid incentivising a focus primarily on the speed with which the reviews are undertaken or total number undertaken.

We also recommend establishing processes to support future outcome measures linked to assessment of the efficacy of particular MBS items, or groupings of items, in supporting patient access to best practice care, and cost-effective investment, as a partial measure for assessing whether the MBS is meeting its goals with regards to supporting universal patient access to quality care in a cost-efficient way.

Relatedly, we also note the need to cement processes to ensure the ongoing revision of the MBS and specific items to ensure they remain reflective of best practice and patient needs, as these evolve over time.

We believe this can be best done in *partnership* with the relevant professional association and professionals in the discipline. Within optometry, as previously mentioned, the Optometric Benefits Consultative Committee (OBCC) provides the foundations for such a process and enables the Department of Health and Optometry Australia, as the professional body, to rigorously consider minor amendments to MBS items that align with the original intent in a timely way (the committee meets twice per year). Whilst there are limitations to this approach, we believe, for the optometry profession, this has provided a base for ongoing amendments to ensure an OMBS that facilitates patient access to required care that accords with contemporary best practice.

Q. Which services funded through the MBS represent low value patient care (including for safety or clinical efficacy concerns) and should be looked at as part the Review as a priority?

Optometry Australia does not believe that there are currently any items listed on the OMBS that represent low value patient care.

There are currently 32 items listed on the OMBS, including four new telehealth items that provide for an optometrist to support a patient in accessing a consult with an ophthalmologist via video consultation and three items that support travel and equipment transfer to provide domiciliary services.

The highest use items on the OMBS support access to an initial comprehensive consultation of longer than 15 minutes for patients less than 65 years of age (Item 10910) and at least 65 years of age (item 10911), or to subsequent consultations (item 10918). The following provides brief comment on how these and other categories of OMBS consultations provide patient value.

Optometry Australia would be pleased to offer further advice regarding the value of these items and of specific OMBS items not discussed here.

<u>Initial comprehensive consultations</u>

Items 10910 and 10911 can only be claimed at specified frequencies of three years and one year respectively.

Indeed, Optometry Australia believes that based on empirical evidence and best practice for the early detection of eye disease, more frequent subsidised access must be supported for those under 65 years of age, and at least biennially for those aged 40-65 years.[6] Prior to 1 January 2015 all patients had been able to access a comprehensive initial consultation of this subsidised under the MBS every two years, regardless of age. Whilst there is sound empirical evidence supporting the need and benefits of those 65 years and over, accessing more frequent comprehensive examinations, we are unaware of an evidence base to support the reduced frequency of access for patients under 65.

Initial comprehensive consultations supported by Medicare are the key mechanism through which many Australians access primary eye health and vision care, and provide a modest cost effective approach for preventing vision loss and detecting eye disease to support early management, minimising avoidable vision loss and in some cases the need for tertiary (specialist) intervention.

Vision loss as a result of eye disease and other vision complaints is a significant health problem in Australia. As noted in the introduction to our submission, in 2009 there were an estimated 575,000 Australians over the age of 40 with some form of vision impairment or blindness. This is expected to increase to over 800,000 by 2020. Given 75% of all vision loss and blindness is avoidable or treatable with early intervention, timely access to primary eye care has proven vital in reducing the heavy social and economic costs associated with avoidable blindness and vision loss, and preventing or slowing the development of ocular and systemic conditions that can require costly specialist care.

Research shows the rate of undetected ocular disease at a population level can be significant, with many ocular diseases typically not exhibiting any symptoms in the early stages of progression, including glaucoma, diabetic retinopathy, age-related macular degeneration and cataract. Increasing age, the increasing prevalence of diabetes and never having had a previous eye examination are all predictors of undetected ocular disease.

A 2003 study of over 24,000 patients investigating the prevalence of undetected eye disease showed 1 out of every 7 people presenting for an optometric eye examination had undetected, asymptomatic eye disease[7]. For those patents aged 40 – 64 years in the study who were found to have an eye disease, more than half were unaware and asymptomatic. The study also found normal vision did not rule out the presence of ocular disease. In another population study in 2013 of 860 patients aged between 19-64 years, 1 in 4 patients presenting with only mild refractive symptoms (asymptomatic for ocular disease) had an underlying eye disease requiring urgent attention[8]. It is very likely many Australians are unknowingly living with an undiagnosed eye disease and may be risking permanent vision loss and blindness. This can detrimentally impact quality of life, as well as government expenditure. Undiagnosed refractive error or eye disease can limit participation in the paid and voluntary workforce, reducing overall productivity,

[6] For an overview of the evidence and Optometry Australia's position see: Optometry Australia (2014) Position Statement on preserving timely access to preventative eye care. Accessed 29/10/2015 via: http://www.optometry.org.au/media/488213/position_statement_preserving_timely_access_to_preventative_eye_care_final.pdf)

[7] Robinson B.(2003) 'Prevalence of Asymptomatic Eye Disease.' *Can J Optom*. Vol 65(5). 175-180.

[8] Michaud L and Forcier P. (2013) 'Prevalence of asymptomatic ocular conditions in subjects with refractive-based symptoms.' *J Optom.* Accessed 9/11/2015 via: http://www.elsevier.es/eop/dx.doi.org/10.1016/j.optom.2013.08.003

as well as result in the need for most costly health care to manage eye disease that has substantially progressed before diagnosis.

A 2005 study looking at the effect of regular eye examinations on functional vision, vision loss and blindness showed people who had more frequent eye examinations were significantly less likely to experience a reduction in their overall vision quality[9]. The economic impact of ocular disease and vision complaints is well known.

Item 10910 and 10911 are claimable if a consultation of over 15 minutes is undertaken. Optometry Australia has outlined the key elements that would reasonably be expected to be addressed in a standard adult primary eye health and vision examination[10]. We believe the conduct of a comprehensive consultation that aligns with these recommendations requires at a minimum, 15 minutes. Surveying of members undertaken by Optometry Australia, suggest that, on average members spend 30 minutes on such consultations.

Other comprehensive consultations

MBS items also exist to support a number of other comprehensive consultations. The majority of these have restrictive eligibility requirements associated with changes in clinical presentations that require an additional comprehensive assessment, or with the existence of progressive or systemic disorders for which more frequent comprehensive assessments are clinically required.

Each of these items supports the provision of a consultation to meet the patient's particular presentation, with the exception of item 10915 which requires a particular assessment to be undertaken of patients with diagnosed diabetes. This assessment is support by the NHMRC as gold standard and recognised by Optometry Australia as best practice.[11]

Subsequent consultations

Item 10918 provides for a subsequent consultation, and for the 2014 to 2015 financial years, was the highest use item on the OMBS (notably it is not age specific, and total initial consultations taken together have higher usage than item 10918.)

This item enables patients to claim a rebate for a second or subsequent consultation in a course of attention, and is vital to providing follow-up care for patients. This item allows for further clinical investigation or management as clinically required. The patient rebate is $33.45.

Contact lens items

Items 10921 to 10930 on the OMBS support the fitting of contact lenses for specified classes of patients, where specification is on the basis of objective clinical measures, where prescription spectacles are not clinically appropriate to managing their eye condition and correcting vision loss. These items are restricted in the frequency with which they can be used (with the exception of item 10930 that enables a refitting on specific clinical presentations) effectively

[9] Sloan FA, Picone G, Brown DS, et al. (2005) 'Longitudinal analysis of the relationship between regular eye examinations and changes in visual and functional status.' *J Am Geriatr Soc.* 53(11): 1867-1874.
[10] Optometry Australia (2015). Position Statement on Provision of an Adult Primary Eye Health and Vision Examination, Accessed 29/10/2015 via: http://www.optometry.org.au/media/642411/position_statement_provision_of_an_adult_primary_eye_health_and_vision_e....pdf)
[11] Optometry Australia, (2015). Clinical Guidelines: Examination and management of patients with diabetes. Accessed 29/10/2015 via: http://www.optometry.org.au/media/460620/clinical_guideline_-_diabetes_revised.pdf

preventing the risk of overuse. We believe these items offer high value patient care. The criteria for eligibility of these items include high degrees of refractive error resulting in thick and heavy spectacle lenses which commonly cause discomfort and are not clinically advised. In some instances, patients with advanced corneal disease (e.g. keratoconus) benefit not only from the comfort of wearing contact lenses but also from significant improvement in vision and quality of life when fitted correctly. Patients with other medical or optical conditions require contact lenses as a part of their management and treatment. This can include the use of a bandage contact lens to protect the eye as a result of previous trauma or injury. A number of these items are relatively low use. The value they offer to the patient's eye health and vision, however, should not be underestimated. Optometry Australia has previously discussed with the Department of Health the potential to amalgamate a number of these items to reduce administrative burden for practitioners and Medicare administrators, provided that overall eligibility of patients and the rebate quantum they can access, is not negatively impacted.

Q. Which services funded through the MBS represent high value patient care and appear to be under-utilised?

As noted above, OMBS items 10931 to 10933 support the provision of domiciliary optometric care and can be billed in addition to a relevant consultation items. In the last financial year (2014-2015), items 10931-19033 were claimed a total of 18,670 times which accounted for approximately 0.2% of the total MBS expenditure for optometry services. As noted above, we believe this reflects only a small proportion of the required domiciliary optometric services in the community.

In 2014-15, 91.2% of the total number of domiciliary services were provided to those 55 years of age or over, an indication that these items are primarily being used by those at higher risk of ocular disease and vision loss including glaucoma, cataracts, macular degeneration and diabetic retinopathy (the risk of which exponentially increase for each with each decade after 40 years of age). It is well established that vision loss has a significant impact on the quality of life for all people and, with particular relevance to older people, is associated with:

- An increased risk of falls;
- Three times the risk of depression and social withdrawal;
- Four to eight times the risk of hip fracture; and
- Premature admission into an aged care facility.

Domiciliary services which support immobile patients to access eye care to help maintain or restore eye health and vision, clearly offer high patient value. Conversely, the impact of this under-utilisation has the potential to impact significantly not only on prevalence of primary eye disease, but also that of primary disability as a result of eye disease.

As noted above, the scheduled fee for domiciliary items is estimates to be around 20% of the true costs of providing a domiciliary service, and provides a significant disincentive for optometrists to provide domiciliary care. Optometry Australia believe the domiciliary loading benefit must more closely represent actual travel and equipment transport requirements, along with other essential tasks optometrists undertake to provide effective and efficient domiciliary eye care. In 2014 Optometry Australia provided a detailed proposal to the Department of Health seeking an increase to the domiciliary loading benefit for optometrists in the MBS. The overall annual expected cost increase to the MBS was minimal.

Items 10942 and 10943 are also both items that we believe are underutilised within the optometry schedule. Item 10942, which supports low vision assessment on eligible patients provides a service of high value to these patients in supporting the identification of their residual vision and opportunities to maximise this through visual aids. This item was billed 5186 times last financial year (0.06% of total MBS expenditure for optometry services). It is difficult to fully identify likely patient population requiring the examination addressed by this item, however, it is well established within the profession and the broader low vision sector, that this item is underutilised.

Similarly, item 10943, which in 2014-15 accounted for 0.96% of total MBS expenditure for optometry services, and allows for the further investigation of binocular vision issues in children between the ages of 3 and 14 years of age, provides a high value patient service which we believe is underutilised.

In both of these cases, providing services eligible for these items requires particular expertise and services are primarily provided through practices and/or by optometrists with a special interest in this kind of care. The additional consultation time required in assessing both low vision patients and children is not reflected in the items as they are currently priced which can be inhibitive to optometrists and optometry practices focusing on the provision of such care. In addition, the expertise and equipment required (i.e. low vision aids including magnifiers, lamps, telescopic aids etc.) to properly assess these patients makes it difficult to financially sustain this aspect of care without proper and fair remuneration.

Q. Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high quality care.

With regard to the OMBS, Optometry Australia does not believe there are any overarching rules that adversely affect patient access to high quality care. There are a number of specific rules that unnecessarily limit patient access to care or cause unnecessary confusion for patient and practitioners, detailed below. We note that there are also a number of overarching requirements for optometrists to participate in Medicare for which the administrative efficiency could be enhanced.

Q. Are there rules which apply to individual MBS items which should be reviewed or amended?

- If yes, which rules and why? Please outline how these rules adversely affect patient access to high quality care.

There are a number of limitations that currently exist with regard to specific OMBS items that require review and amendment.

- The schedule, which is predominately time based, in many instances restricts patients from accessing care by allowing access to items only after a certain time period has lapsed. For example, from 1 January 2015, a comprehensive eye examination (Item 10910) for a patient less than 65 years of age can only be accessed once every 3 years. If a patient is unaware of a progressive disorder or eye disease that may have manifested in the interim, early intervention and treatment may be delayed as a result of this limitation. As noted above, this does not accord with best available evidence, best practice or international recommendations, all of which support more frequent

comprehensive eye examination for consumers who may not have specific symptoms. A 2005 study looking at the effect of regular eye examinations on functional vision, vision loss and blindness showed people who had more frequent eye examinations were significantly less likely to experience a reduction in their overall vision quality.[12] The American Optometric Association recommends biannual eye examinations for asymptomatic adults between 41 – 60 years and considered low-risk of ocular disease.[13] Similarly, the Canadian Association of Optometrists recommends adults between 40-64 years should undergo a comprehensive eye examination every 2-years.[14]

Further, and as also noted above, there appears to be no sound evidence base supporting the decision to reduce the frequency with which younger consumers can access a comprehensive eye examination from an optometrist.

- Item 10905 of the OMBS supports a comprehensive initial consultation on referral from another optometrist. This is of value where a second opinion is considered clinically required and where the second optometrist has specific skills in an area of practice relevant to the patient's care. This item can currently only be billed for instances where the referral was provided by an optometrist. The item does not support consultations on referral from a General Practitioner (GP) or other medical practitioner. Patients who have been referred to an optometrist by their medical practitioner but attended another optometrist in the last 36 months or 12 months (depending on their age) cannot access a rebated at a level of a comprehensive eye examination unless they meet the eligibility criteria for items 10912, 10913, 10914 or 10915. Research undertaken by Optometry Australia has demonstrated that it is not uncommon for GPs to refer a patient to an optometrist because they are better equipped to assess the patient's eye health (access to slit lamp or diagnostic drops and/or dyes) or more knowledgeable in a particular aspect of eye care, and the patient be unable to access a rebate at the rate of a 10905. Many of these patients attend for eye examinations that require complete examination which may include dilated fundus examination, pupil assessment, colour vision assessment and visual field screening. In such instances the patient may be only able to access a lower rebate under item 10907 which is not aligned with the resources required to comprehensively assess the patient. We believe this disadvantages patients and can impact their capacity to access recommended care, particularly if they are unable to afford an out-of-pocket expense and the practice is unable to absorb the cost of providing a long comprehensive consultation for a low rebate. Optometry Australia has previously made a submission to the Department of Health, seeking minor amendment to item 10905 to enable it to be billed on referral from another optometrist, or a medical practitioner, where items 10910-10915 cannot be applied.
- Items 10931-10933 provide a domiciliary loading in addition to the consultation fee. Practitioners who often claim these items offer an important service to a, generally

[12] Sloan FA, Picone G, Brown DS, et al. 'Longitudinal analysis of the relationship between regular eye examinations and changes in visual and functional status'. *J Am Geriatr Soc*. 2005. 53(11): 1867-1874.
[13] American Optometric Association. (2003) Recommendations For Regular Optometric Care.
[14] Canadian Association of Optometrists. (2013.) Position Statement: Frequency of Eye Examinations.

older demographic in Residential and Aged Care Facilities, or in their in home. Medicare statistics in the last financial year show that these domiciliary items are claimed over 90% of the time on patients over 55 years of age, an age group where a strong prevalence of eye disease including cataracts, macular degeneration and glaucoma exists. There is however, a current restriction on the use of items 10940 and 10941 (automated threshold visual field testing) in conjunction with items 10931-10933. With current technology and contemporary equipment allowing for the use of portable visual field machines, it would seem best practice and most appropriate for items 10940 and 10941 to be able to be accessed in conjunction with the domiciliary loading benefit. The prevalence of glaucoma, a disease that is asymptomatic until the patient notices a visual field defect, is significantly greater in this population and only through visual field testing and early intervention can further loss and blindness be prevented.

- In the explanatory notes of the optometric MBS, it states that: *The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses.* In the current climate where many consumers are turning to the internet and purchasing contact lenses online, it would appear that the current limitation, whereby a Medicare fee is payable only when linked with the retail sale of contact lenses, is not in line with current practices. Optometry Australia would strongly suggest that if the practitioners has successfully completed the contact lens fit, including the fitting process, patient tuition and subsequent aftercares as required, then the Medicare benefit under items 10921-10930 should be payable, regardless of where the patient chooses to purchase their actual supply of contact lenses.

Q. What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

We believe there are a number of ready opportunities to better support clinicians and consumers to understand the rules and regulations that apply to OMBS items and to support accurate billing. With regard to OMBS items, consumer knowledge is predominantly derived from optometrists providing the patient care. This underlines the necessity of ensuring that practitioners themselves have a sound understanding of the OMBS and what rules apply.

From the outset, consultation with the relevant profession to ensure clarity of wording in item descriptors and appropriate explanatory notes that have relevance to contemporary practise, is important to ensuring that items are developed and introduced to clinicians in a manner that supports clarity and appropriate billing.

For the optometry sector, we recommend consultation occur via Optometry Australia as the peak body for the optometry profession, with a membership of close to 90% of all registered optometrists in Australia. Our experience has been that commitment to an appropriate level of consultation is intermittent. Recently, for example, a new item for removal of an embedded corneal foreign body has, following application by Optometry Australia, been added to the OMBS. Consultation regarding the *final* language used in the listing of the item and the explanatory notes did not occur. The wording of the item descriptor created considerable confusion on a number of levels. This item stipulated that if both the corneal foreign body and rust ring was not fully removed, then only item 10916 would be payable. There are instances

when best practice would suggest a rust ring is removed a day or two after the corneal foreign body is removed. The item, as it is interpreted in the explanatory notes, does not allow for such occasions. In addition, item 10916 is specifically for brief initial consultations of not more than 15 minutes. There are occasions where a patient may not have the rust ring removed or not completely removed the corneal foreign body, however the consultation take in excess of 15 minutes. Once again, the item descriptor as it is listed in the *published schedule* does not allow for this possibility, though the *item descriptor* in the regulations does. We believe such confusion could be avoided through appropriate consultation with peak bodies for relevant professions.

Additionally, and notwithstanding that optometry is a highly compliant profession, further education from Medicare for optometrists would enhance compliance where non-compliance results from misunderstanding or ambiguous item descriptors and explanatory notes. In optometry, one of the most effective ways to communicate with clinicians is through Optometry Australia and its state bodies. In the past Medicare officials provided regular educatory advice through Optometry Australia's monthly newspaper, and through participation in well-attended professional development conferences hosted by Optometry Australia's state bodies. In recent years these practices have ceased, seemingly to accord with Departmental policy. Optometry Australia has frequently requested the Department of Human Services provide educatory resources for optometrists, however this has not occurred. Optometry Australia dedicates significant resources to supporting members to comply with Medicare rules and regulations and bill appropriately. Our daily discussions with optometrists seeking clarity on how to bill appropriately in specific circumstances serves to underline that most practitioners are committed to compliant practice. Appropriate educatory resources from Medicare Australia which addressed frequently asked questions could effectively further enhance compliance within the profession.

Similarly, better access to quality advice regarding appropriate billing in specific circumstances, from a dedicated optical advisor or through an alternate Medicare official with a history of understanding the Schedule, would better assist practitioners when faced with uncertainty in billing. Too often optometrists who seek such advice from Medicare receive responses that directly quote the OMBS without specifically advising on the point of contention that has been raised. It is also not uncommon for optometrists to receive advice from Medicare that may contradict prior advice provided to Optometry Australia or another optometrist, or which those well acquainted with the OMBS readily recognise as inappropriate. Quality, published advice provided in a timely manner would support a greater understanding of the OMBS amongst the profession, and support compliant billing.

In addition, the availability of individual statistics with respect to billing practices and how this compares to the rest of the profession, can provide useful insights into billing patterns and help promote accurate billing. Whilst this data is available via an online portal, it is not readily accessible nor regularly promoted. In the past this information was proactively sent to all optometrists, helping ensure it was accessed by a large proportion of the profession. We recommend a return to this proactive approach from the Department of Human Services, in the interests of promoting appropriate billing.

Q. What kind of information do consumers need to better participate in decisions about their health care?

Optometry Australia believes that consumers should be empowered through patient-centred care and increased health literacy, to make informed decisions regarding their health and healthcare. This requires, in many instances, a refocus of the patient-clinician encounter and an enhanced focus on health literacy for all consumers, including community awareness campaigns. With regard to consumer understanding of the OMBS, we believe that understanding that they can access subsidised and affordable optometry consultations on a reasonably regular basis and, in many circumstances, when clinically required, is important to ensuring consumers access needed eye care in accordance with best practice for prevention, early detection and treatment of eye and vision problems. Perceived costs of eye care can provide a barrier to consumers accessing care. A recent survey conducted by Optometry Australia has shown reduced presentations to practices associated with perceived ineligibility for Medicare rebates for patients, following changes to the OMBS introduced from 1 January 2015.

However, we also note the relative complexities of the OMBS and that it is often unclear what item is billable for a patient, due to the links between clinical presentations and item eligibility, until part way through their consultation and on determination of how recently they accessed a linked item. Given this we believe it is important to balance the need for consumer information regarding the OMBS with the need to limit unnecessary confusion and any associated stress. We believe it is not appropriate to seek to specifically provide consumers in general with a greater understanding of the different items on the OMBS, unless specifically sought by the consumer. To do so may cause unnecessarily confusion and anxiety. Indeed, this is a relatively frequent outcome of instances where Medicare officers provide patients with advice on what their optometrist should be billing for their care, without an in-depth understanding of the OMBS rules and of the clinical presentation, examination or procedure. Frequently this is not aligned with OMBS requirements.

However, it is likely to be appropriate to ensure that patients understand under what circumstances they are next likely to be eligible for a rebate for clinically appropriate care.

Optometry Australia strongly believes that consumers should be supported to make informed decisions about their healthcare, including on consideration of expected out-of-pocket expenses. Optometrists are rightly required to advise patients of potential costs associated with their consultation.

Optometry Australia
204 Drummond Street Carlton VIC 3053 | 03 9668 8500 | Fax 03 9663 7478
PO Box 185 Carlton South VIC 3053 | optometryaustralia@optometry.org.au | www.optometry.org.au