

Medicare compliance and Consultant Physician treatment and management plan items 132, 133, 92422, 92423

The Department of Health, Disability and Ageing (department) has identified possible compliance concerns relating to claiming of Medicare Benefit Schedule (MBS) Consultant Physician treatment and management plan items 132, 133, 92422, and 92423. This document provides an overview of observed behaviour in the **Respiratory and Sleep Medicine provider group**.

Background

Professional attendance services are the largest contributor to overall MBS expenditure. Specialist and consultant physician items are driving growth, with **over \$2.2 billion in Medicare benefits** paid to **more than 26,000 unique** specialists and consultant physicians for attendance and management items in financial year 2024-25. Monitoring claiming of these items is a current compliance priority for the department. Our focus is on ensuring practitioners understand how to correctly claim these items to ensure the future sustainability of the MBS.

Treatment and management plans

MBS items 132-133 (face to face services) and 92422-92423 (telehealth services) are for the development and review of a comprehensive treatment and management plan for patients with complex needs that is provided to the referring practitioner to assist with the patient's long-term management.

- **MBS item 132:** a comprehensive initial assessment by a consultant physician for a patient with at least 2 morbidities to develop a plan that is provided to the referring practitioner. The assessment must last at least 45 minutes and include a detailed history, examination, and development of a treatment and management plan of significant complexity. MBS item 92422 is the telehealth equivalent. As stated in Explanatory Note AN.0.23, it is anticipated the majority of patients will be able to be managed effectively by the referring practitioner using this plan.
- **MBS item 133:** a follow-up review of the treatment and management plan initially developed under item 132. The review must last at least 20 minutes and can be claimed up to twice in the 12-month period following the claiming of item 132. MBS item 92423 is the telehealth equivalent.

For further details and guidance on claiming these items refer to [MBS explanatory note AN.0.23](#).

Respiratory and Sleep Medicine and use of treatment and management plans

Claiming by Respiratory and Sleep Medicine providers



740 practitioners claimed preparation of a treatment and management plan, representing about 79% of all respiratory and sleep practitioners.



Around **7% of these practitioners focused more on paediatric care**. Providers were classified as paediatric specialists if at least **50% of their patients** were aged under 18.



Over **120,000** treatment and management plan services were claimed.



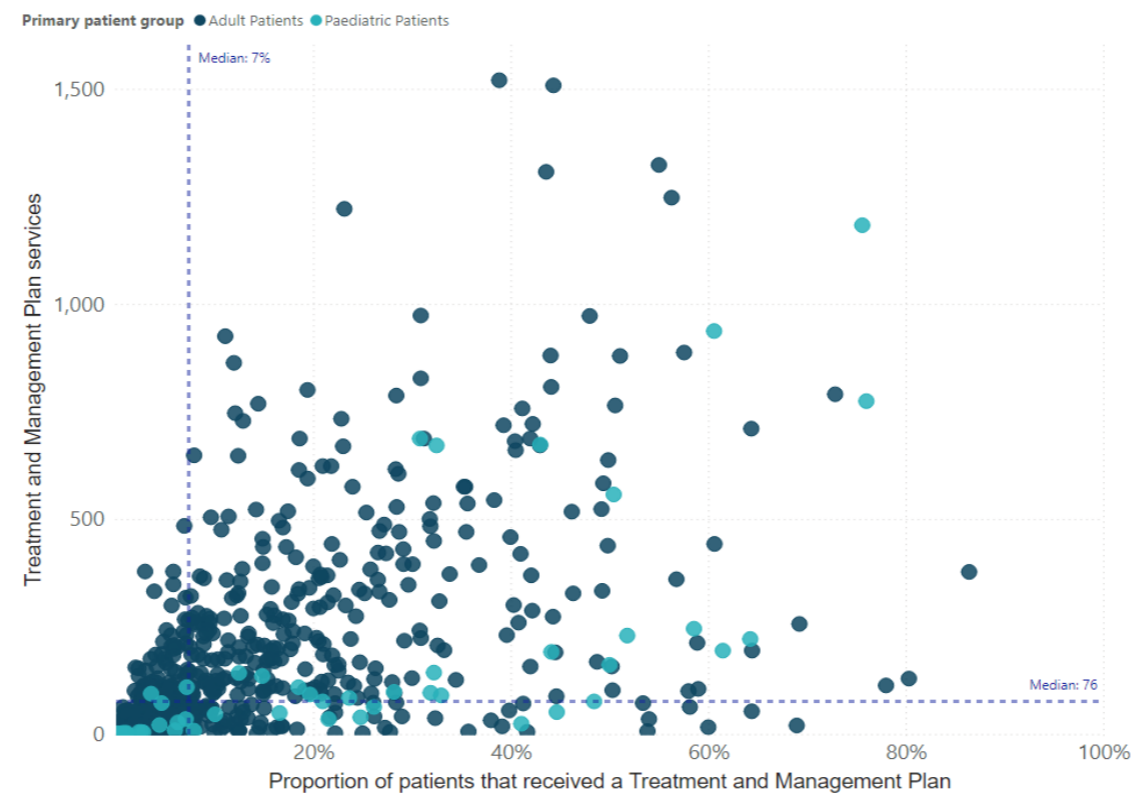
Over **\$25 million** in Medicare benefits were paid.



The respiratory and sleep medicine provider group ranked **4th** by service volume out of all provider groups claiming these items.

Concern 1: High servicing of Consultant Physician treatment and management plans

Data Period: 1 April 2024 to 31 March 2025



Median number of services claimed by individual Respiratory and Sleep Medicine providers = **76 services**

Outliers have been removed to ensure there is no reasonable likelihood of re-identification of providers occurring

Treatment and management plans are intended for patients with complex needs and are not expected to be routinely claimed for all patients. Where claimed, it is anticipated that most patients will be able to be managed effectively by the referring practitioner using the treatment and management plan.

Claiming these items in high volumes and/or significantly differently to peers could be an indicator of inappropriate and/or incorrect claiming, such as:

- not meeting time requirements
- patients not having at least 2 morbidities
- not providing the referring practitioner with a treatment and management plan of significant complexity, to assist with the patient's long-term management
- use as a complex consultation rather than for plan creation.

This graph shows **740 practitioners** who have claimed treatment and management plans:

- **X-axis:** The proportion of each practitioner's patients that received a treatment and management plan service
- **Y-axis:** Indicates the number of treatment and management plan services claimed.

Note: High servicing alone is not a direct indicator of non-compliance. For some practitioners, high servicing may be justified based on factors including location and patient demographic. Claiming these items should be determined based on a patient's individual needs.



Concern 2: Routine/Repeat claiming of initial Consultant Physician treatment and management plans – items 132 and 92422

Initial treatment and management plans are restricted to one claim per 12 months for the same patient by the same practitioner. After that period, if a practitioner continues to see a patient for ongoing management of the same condition, they are not entitled to claim a new initial plan. It is expected that ongoing services would be claimed under review item 133 or subsequent attendance items, such as MBS item 116.

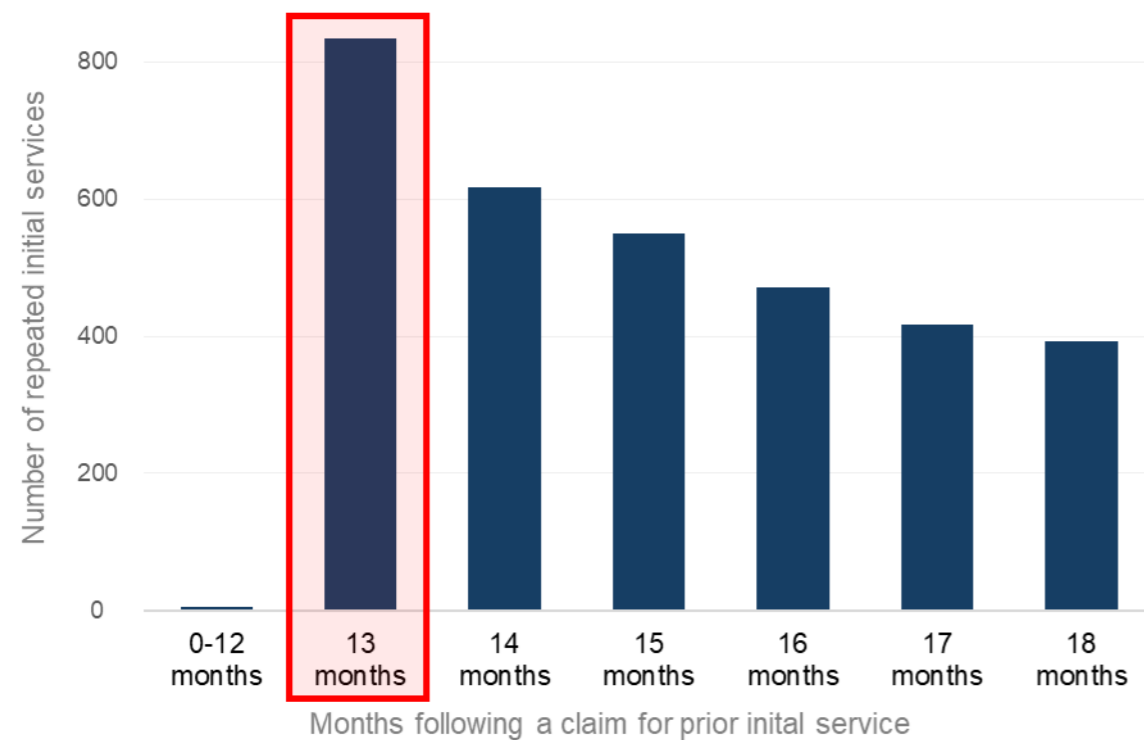
If a patient's condition or care requirements change, necessitating a new plan, and more than 12 months have elapsed since item 132 was claimed, it is possible to claim another initial assessment. Standard requirements for commencing a new course of treatment would need to be met, including that:

- The referring practitioner considers the new assessment is necessary
- It is more than 9 months since the specialist or consultant physician last saw the patient
- The period of validity of the previous referral has ended and a new referral is provided.

Data analysis has **found a notable trend of initial plans claimed in the 13th month following a prior claim of an initial plan for the same patient (i.e. a repeat initial plan service)**. Repeat claims in the 13 month by respiratory and sleep medicine providers are highlighted in red in the graph below.

While some claims may be valid due to changes in the patient's condition or emergence of a new issue, this spike suggests that claims may be based on expiry of time restrictions, particularly if individual practitioners have a significant volume and/or proportion of their patients with this claiming pattern.

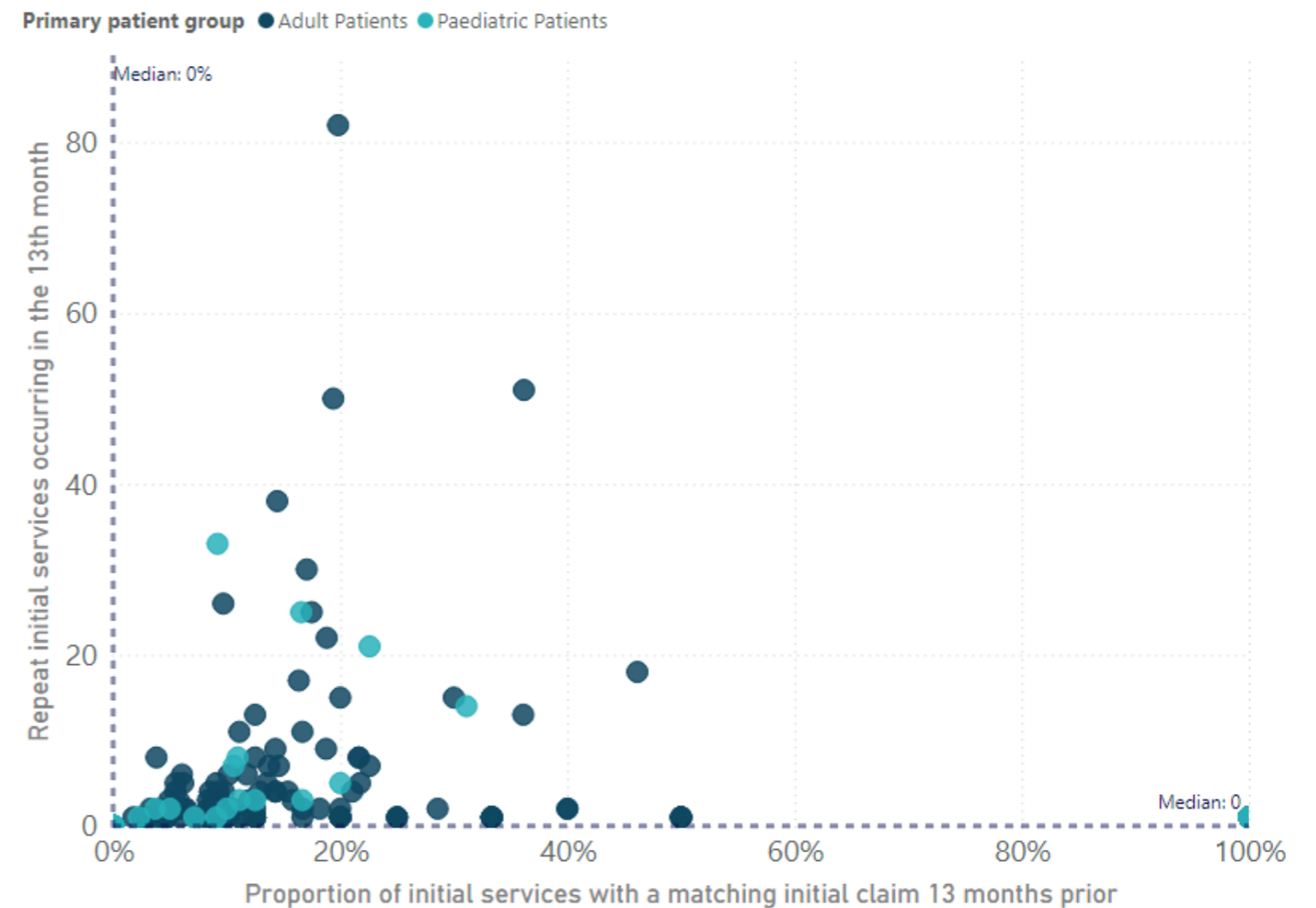
Data period: 1 April 2024 to 31 March 2025



The graph below shows **143 Respiratory and Sleep Medicine providers** that claimed a repeat initial plan in the 13th month following a previous claim for the same patient.

- **Y-axis:** The number of initial plans claimed in the 13th month following a previous claim
- **X-axis:** The proportion of each practitioner's initial plans that had a matching claim for the same patient 13 months prior.

Data period: 1 April 2024 to 31 March 2025

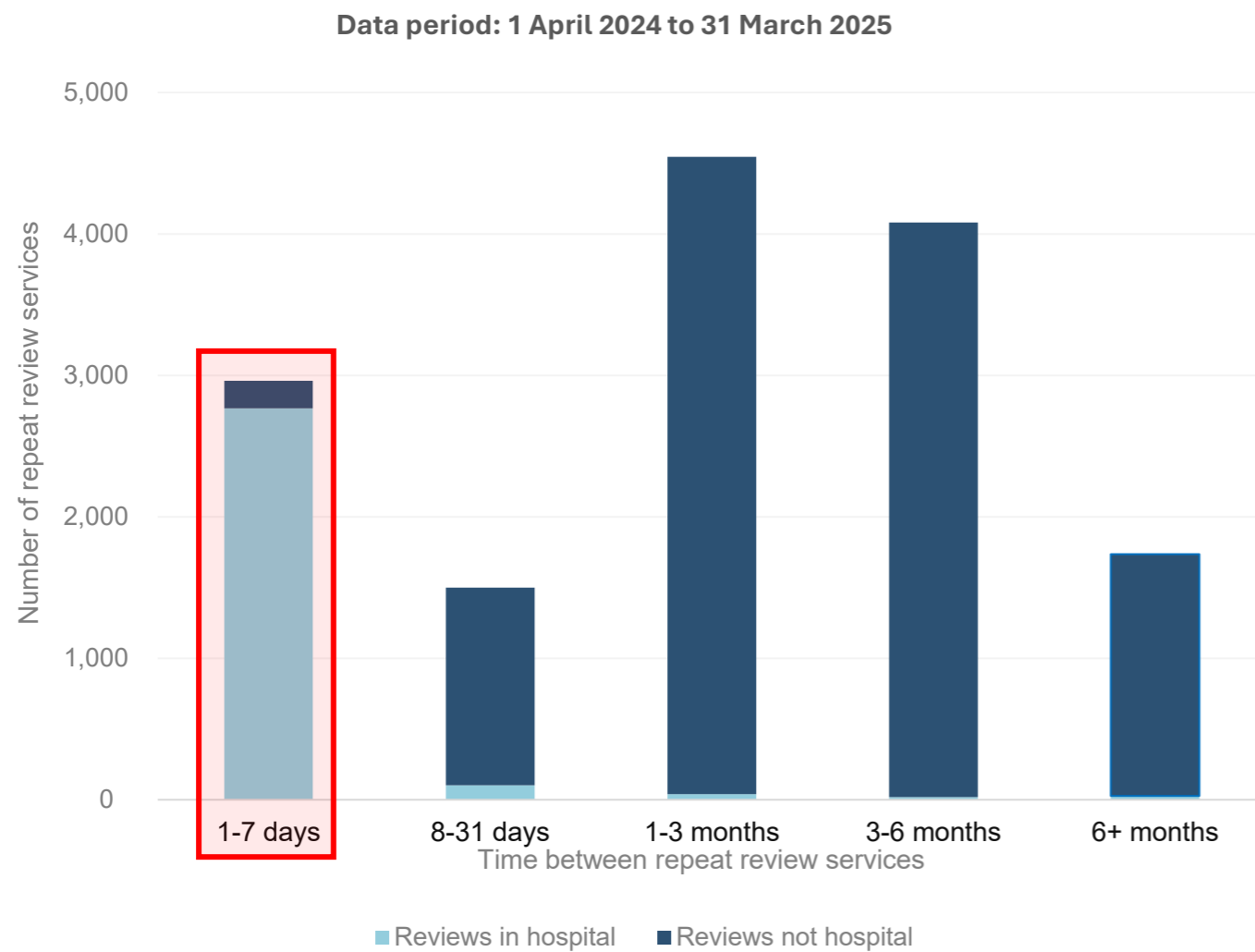


Concern 3: Claiming repeat reviews of Consultant Physician treatment and management plans within a short time – items 133 and 92423

Following its creation, review of a treatment and management plan is restricted to 2 claims in the following 12 months for the same patient by the same practitioner. A review service is intended for use when a change in a patient’s circumstances or condition requires a modified plan to be provided to the referring practitioner.

It is not expected that a review would be necessary soon after implementing the initial plan, or that an additional review would be required soon after a previous review. It is anticipated that most patients will be able to be managed effectively by the referring practitioner using the management plan, inferring that the patient’s condition is stable enough to allow this. At a minimum, sufficient time should elapse for the patient to undergo and respond to the recommended treatment and management plan.

Data analysis has **found a significant number of repeat review claims within 7 days of a previous review claim. The majority of these repeated reviews within 7 days appeared to occur in hospital.** While some cases may be justified by unexpected changes in a patient's condition, this pattern is not expected to be common. Repeat claims by respiratory and sleep medicine providers within 7 days are highlighted in red in the graph below.



The graph below shows **198 Respiratory and Sleep Medicine providers** who claimed a review within a week of claiming another review for the same patient.

- **Y-axis:** The number of review services claimed within 7 days of an initial review by each practitioner
- **X-axis:** The proportion of each practitioner’s reviews that were repeated within 7 days.

