National Centre for Classification in Health

PROFESSIONAL RELATIVITIES STUDY

RESOURCE MATERIAL I

Professional Relativities Technical Committee (PRTC)
Meetings 1 & 2: agenda papers & reports

NCCH agenda papers and reports of the meetings of the PRS PRTC. The PRTC established the rules, regulations and definitions for the PRS.

Part 1 - Meeting of 14 February 1998

prepared for
Medicare Schedule Review Board
December 2000

Professional Relativities Study

Professional Relativities Technical Committee

Documentation for Meeting No. 1

23 August 1997

National Centre For Classification In Health

Professional Relativities Technical Committee Documentation

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1. Agenda

Professional Relativities Study

Professional Relativities Technical Committee Meeting No. 1

TIME:	**9:30 am - 5:00 pm**
DATE:	**Saturday 23 August 1997**
VENUE:	**Kingsford Room, Sydney Sheraton Airport Hotel Cnr O'Riordan and Robey Streets, Mascot**
CONVENOR:	**A/Prof. Rosemary Roberts**

AGENDA

Time		Agenda Item			Minutes
09:30	**1.**	**Introduction**			20
		1.1.	Aims of the day Agenda Items		
		1.2	Guidelines for PRTC		
09:50	**2.**	**Background**			40
		2.1	Study Methodology		
		2.2	Workplan/Timeline		
		2.3	Project Management and Committee Roles		
10:30		**MORNING TEA**			15
10:45	**3.**	**Technical Working Papers**			
10:45		3.1	Study Definitions		110
11:45		3.2	Formula for use in study	10	
12:45		**LUNCH**			30
13:15		3.3	Criteria - good maps, core and link items	60	
14:15		3.4	Methodology - for applying definitions, formula criteria		60
15:15		**AFTERNOON TEA**			15
15:30		3.5	Other - parameters for study application		60
16:30	**4.**	**Summary**			15
16:45	**5.**	**Next Meeting**			15
17:00		**CLOSE**			

Professional Relativities Study

Professional Relativities Technical Committee

ATTENDEES

Clinical Members:

Dr Robert ALLAN
General Practitioner

Dr Robert BLACK
General Surgeon

Dr G Patrick BRIDGER
ENT Surgeon

Dr Greg DEACON
Anaesthetist

Dr Paul DUGDALE
General Practitioner

Dr Finlay MACRAE
Gastroenterologist

Dr Michael RICE
Paediatrician

Medicare Schedule Review Board:

Dr Stephen CLARKE
Australian Medical Association

National Centre for Classification in Health:

Ms Barbara ANDERSON
Meeting Facilitator

Ms Kay BONELLO
Meeting Facilitator

Ms Patricia DAHDAH
Specialty Group Analysis

Ms Kerry INNES
Assoc. Director (Meeting Facilitator)

Ms Lauren JONES
Project Manager

Ms Sheelagh NOONAN
Assistant Project Manager

Mr George RENNIE
Statistician (OR Systems P/L)

A/Prof. Rosemary ROBERTS
Director (Convenor - PRTC)

Ms Sue WALKER
Assoc. Director (Meeting Facilitator)

Medicare Schedule Review Task Force:

Mr Col BAILEY
Mr John POPPLEWELL
Mr David REDDY

1.3 PRTC GUIDELINES

Guidelines to be followed by the Professional Relativities Technical Committee in establishing the ground rules for setting professional relativities

1. The services to be addressed are those in the General Medical Services Table of the Medicare Benefits Schedule. That is, they exclude pathology and diagnostic imaging services.

2. Services to be covered include consultations and attendances, therapeutic procedures and miscellaneous diagnostic tests and investigations. The new draft structure for consultations and attendances should be regarded as replacing the existing one. Itemisation of other services should remain as at present.

3. A separate Committee has been established to examine the pros and cons of bundling versus unbundling the post operative component of procedures.

4. **The PRTC's work is confined to establishing the ground rules for setting the relativities of the professional work components of services** Work is to be assessed as the product of professional time and professional effort or intensity involved in rendering a service. Factors which bear on the different earning rates that might apply to professional work components (such as possible higher rates to account for the opportunity costs of specialist training, after hours loadings to compensate for disruption to family life etc), rather than those related to the intrinsic nature of the work itself, must be put aside as they are covered by a separate consultancy which is examining remuneration issues.

5. Similarly, other resources employed in providing a service such as technical and nursing staff, consumable, administrative effort etc. are being considered in a separate practice cost consultancy.

6. The focus should be on single service episodes only. That is, each service should be considered in a "stand alone" context.

7. All services have pre, intra and post components which will need to be identified in order to properly account for times and variations in intensity between components. Also, it is expected that there will be considerable variability in intensity within the intra components of many services. In setting the ground rules it must be clearly established when and where a service starts and stops, when and where the components start and stop and that **average rather than peak intensities are to be determined for each component**. (Please note item 3 above relating to bundling versus unbundling of post operative care.)

2. Background

2.1 Study Methodology

2.2 Workplan/Timeline

2.3 Project Management and Committee Roles

2.1 STUDY METHODOLOGY

INTRODUCTION

The Professional Relativities Study (PRS) is being conducted by the National Centre for Classification in Health (NCCH) for the Medicare Schedule Review Board (MSRB). The definitive study follows on from a feasibility study carried out in 1996 and early 1997 by the NCCH for the MSRB to examine the potential for mapping the professional components of services described in overseas schedules with the Medicare Benefits Schedule (MBS).

The overall aim of testing the mapping between the MBS and CPT was to see if the resource based relative value units developed in the United States during the 1980s and applied to the American Medical Association's Current Procedural Terminology (CPT) could be applied to mapped MBS items.

Only the Therapeutic Procedures in Category 3 of MBS were in scope for the feasibility study. That study demonstrated that it is possible to map between MBS and CPT and to gain consensus from expert clinicians on relative intraservice work (time and intensity) for items in the MBS. However, the maps are not sufficiently robust on their own to determine the relative values of the mapped MBS items.

The PRS includes Australian clinician input to decide on a representative group of procedures within each specialty for which resource based relative values will be determined using a range of data including Australian intraservice times, estimates of intensity and maps between MBS and CPT. The relative value units determined for these core items will be used to establish relative values for all items within a specialty and to establish link items between specialties. The definitive study covers 26 specialties (Attachment 1) and the following categories of MBS:

Category 1 - Professional attendances
Category 2 - Diagnostic Procedures and Investigations
Category 3 - Therapeutic Procedures
Category 4 - Oral and Maxillofacial Services

The study requires a complex organisational effort to bring together specialty groups of clinicians and technical advisers in a series of meetings which are interrelated and which will result in advice and reporting to the MSRB at regular intervals.

METHOD

The ultimate outcome of the PRS project is a set of work related Relative Value Units (RVUs) for all items in Categories 1-4 of the MBS. These RVUs should be formula based to:

(a) make explicit the basis for the Resource Based Relative Value Scale (RBRVS)
(b) maximise acceptance by the medical community, and
(b) facilitate future updates

Attachment 2 outlines the study phases and processes and shows the involvement of committees in terms of time and roles. The methodology is described by the following stages:

1.	**Establish rules and regulations for study**	**PRTC**
2.	**Map MBS/CPT items**	**NCCH**
3.	**Sort MBS item numbers by specialty for RVU development**	**NCCH**
4.	**Rank items based on total work value (items will be pre-sorted according to anaesthetic times to assist with this process), confirm times and rate intensities for selected items**	**CCs**
5.	**Regress rankings against times and intensity ratings to develop formula. Estimate efficacy of formula and its' consistency with rankings**	**NCCH (Statistician)**
6.	**Choose core and link items based on MBS item ranks, good maps, and frequencies**	**NCCH/ CCs**
7.	**Provide RVUs for core items based on the US RVUs from good maps and information on times and intensity ratings**	**CCs**
8.	**Complete estimates of times and ratings of intensity**	**CCs**
9.	**Project core RVUs to remaining items using rankings**	**NCCH (Statistician)**
10.	**Re-evaluate formula and test application to RVUs for all items**	**NCCH (Statistician)**
11.	**Ratify draft RVUs and link items**	**CGs**

The study stages are discussed in more detail over page.

1. Establish rules and regulations for study

The PRTC is responsible for recommending definitions, rules and criteria for application throughout the study.

2. Map MBS/CPT items

The MBS items are being mapped to CPT codes in order to inform about appropriate CPT RVUs for use in the PRS. Maps are being undertaken from MBS items to CPT codes (forward maps) and from CPT codes to MBS items (backward maps). The 'good' maps will be used as a major criterion for the selection of core items for which RVUs will be developed. The basis for judging a map as 'good' will be reliant on the map ratio and rating and the degree of consistency of terminology of MBS items and CPT codes.

3. Sort MBS item numbers by specialty for RVU development

It is important to the outcome of the project that item numbers are categorised according to the speciality in which medical clinicians provide their services. Information received from the Medicare Benefits Branch (i.e. frequencies of services provided by MBS item numbers for specialty groups) will be analysed in order to categorise each item to a specialty. Where MBS items are used by several specialists they will be reviewed by those specialty groups which provide the highest proportions of services; preferably a maximum of two specialty groups per item.

4. Rank items based on total work value (items will be pre-sorted according to anaesthetic times to assist with this process), confirm time estimates and rate intensities for selected items

In order to choose core items, test the validity of a formula and ensure the ability to replicate RVUs for MBS items, it is necessary to rank the items (total N) within each specialty in terms of the **total work value.** The ranking of the items is also necessary to enable the relative value determinations for the core items to be projected to the remaining items and will serve as the focal point in the development of the formula. In this context ranking means ordering items from 1-N where 1 is the item of most value to the specialty and N is the least. Where items are of equal value, these can be ranked together.

The CCs will be requested to **rank** the MBS items (based on total work value) within their specialties as soon as practicable once criteria have been developed by the PRTC. Clinicians will be provided with MBS items sorted by anaesthetic times or a proxy time. Printouts will be produced for all specialties and these will be sorted by MBS item number and overall rankings. Table 1 over page is an example:

TABLE 1
Ranking of MBS items

MBS Item Number	Desc.	Freq.	Overall Rank
XXXX	Radical	23	1
YYYY	Removal of	735	2
ZZZZZ	Biopsy.....	2745	3

Some confirmation of time estimates and ratings of intensity will also be undertaken in stage 4.

The CC groups will be asked to:

a) **Estimate** pre, intra, post direct and indirect times as agreed by the PRTC
b) **Rate** within specialty
   i. mental effort and clinical judgement,
   ii technical skill and physical effort, and
   iii stress due to risk.

This has been illustrated in Table 2 below.

TABLE 2
Time Estimates and Ratings of Intensity

MBS Item Number	Desc.	Freq.	Rank	Quality of map	Component ratings			Time		
					Effort	Skill	Stress	Pre	Intra	Post
XXXX	Radical	23	1	2	10	9	8	60	120	30
YYYY	Removal of	735	2	1	8	7	8	30	60	30
ZZZZZ	Biopsy.....	2745	3	4	4	2	3	5	25	5

At this stage, estimates of time and ratings of work components for 20% of MBS items within each specialty would be necessary for preliminary testing of the formula.

5. Regress rankings against times and intensity ratings. Estimate efficacy of formula and consistency with rankings.

Regression analysis will endeavour to explain the ranking of total work value in terms of times and intensity. This will have two purposes:

a) to test possible formulae
b) to provide feedback to the CCs about their rankings and ratings

6. Choose core/link items based on MBS item ranks, good maps, and frequencies

Core item selection will be based on the rankings provided by the CCs, the 'good' maps and frequency data. Both core and link items should ideally be high frequency items which have good maps and are evenly distributed throughout the rankings.

7. Provide RVUs for core items based on the US RVUs and the time and intensity ratings data

RVUs for CPT items for good quality MBS maps will be presented to the CCs who will be asked to review these relative values using the time estimates, intensity ratings and other information. Note that while the ranking of items and the estimation of times and the ratings of effort, skill and stress are significant data for the estimation of a formula, **they do not link this formula to relative value.** This step is accomplished by the RVU estimation for the core items. In this light the estimation of RVUs for the core items can be viewed as a calibration.

8. Complete estimation of times and ratings of intensity

This work needs to be completed for validation of extrapolation/interpolation and ultimately so that all relative values can be formula based so that the final outcome of the project is based on a credible and defensible methodology.

9. Project core RVUs to remaining items using rankings

This will initially be accomplished via interpolation using the rankings and later revised on the basis of time estimates and ratings of intensity.

10. Re-evaluate formula and test application to RVUs for all items

The regression analysis of step 5. will be repeated using the full data and interpolation of non core RVUs refined accordingly.

11. Ratify draft RVUs and link items

To assist them in their review, the CGs will be provided with ordered lists of all items within each specialty. These will contain the draft times, intensity ratings, RVUs and a comparison of the RVUs with the rankings previously provided by the CCs.

STUDY PHASES

The methodology has been presented in terms of the study phases in the Table 3 below. At the end of each phase, results will be reported to the MSRB so that subsequent phases can be redirected if necessary. See also flow chart in Attachment 2.

TABLE 3
PRS Study Phases

PHASE 1 - three months (July- September 1997)

Step 1	**PRTC**	Recommend definitions, rules and criteria for application throughout study
Step 2	**NCCH**	Map all items in MBS Categories 1 - 4 (as of May 1997 - undertaken concurrently with steps 1-5) Evaluate quality of maps using criteria established by PRTC.
Step 3	**NCCH**	Sort all MBS items (Categories 1-4) into specialty groups - separating attendance items from diagnostic and procedural items.
Step 4	**CCs**	? ratify MBS items selected by the NCCH for study within each specialty group ? rank all items within their specialty in terms of total work and in accordance with criteria set by the PRTC (the NCCH will have pre-sorted items in terms of anaesthetic times or proxy time to assist with this process) ? estimate pre, intra and post times and rate effort, skill and stress for 20% of items *Note:* this work would be undertaken by correspondence
Step 5	**NCCH (Statistician)**	Develop preliminary formula on the basis of the information assembled through step 4.
Step 6	**PRTC**	Present results of formula testing, and mapping to second meeting of PRTC.
Step 7	**APPRMS**	Meet with Advisory Panel on Professional Relativities for Medical Services (APPRMS) to review definitions, rules and criteria
Deliverables	**NCCH**	First Interim Report to MSRB - Board to approve definitions, rules and criteria.

PHASE 2 - Five months (October- February 1997)

Step 8	**NCCH**	Assemble additional data including frequencies for CPT mapped items, actual theatre times from hospital operating theatre systems, information from Department of Health and Family Services operating theatre service weight study, anaesthesia times for MBS items and MBS relativities using existing fees.
Step 9	**NCCH**	Draft core and link items (for each specialty covering a representative range of activities based on quality maps with CPT, ratings of MBS items, volume, the cost of services and attendance items).
Step 10	**CCs** **NCCH**	Meet with CCs to establish RVUs for MBS core items and to complete the estimation of pre, intra and post times and the rating of effort skill and stress. There will be 26 CC meetings held for procedural items and the Consensus Group (CG) on attendance items would hold its first meeting at this stage. The CCs will: ? check query maps ? check maps of all core items ? ratify core and link item selection on which inter and intra professional relativities will be established ? rate core and remaining items in terms of intensity (effort, skill and stress) and estimate times (pre, intra, post) (note: excluding those already rated for formula testing) ? develop RVUs for core items based on CPT RVUs
Step 11	**NCCH (Statistician)**	Project core RVUs to remaining items using rankings. Re-evaluate formula and test application to RVUs.
Step 12	**NCCH**	Distribute and present results of CC core RVUs to Consensus Groups (CGs) for confirmation of RVUs (all steps in the development of the RVUs by CCs will be presented).
Step 13	**CGs**	Meet with the CGs to ratify the draft RVUs and link items.
Step 14	**CGs**	Meet with CG for attendance items for a second time to determine attendance item RVUs and provide those RVUs to MSRB for consideration with relativities of therapeutic items.
Deliverables	**NCCH**	Second Interim Report to MSRB - Board to approve work to date

PHASE 3 Three months (March - May 1998)

Step 15	**NCCH**	Revise RVUs based on CG recommendations.
Step 16	**APPRMS**	Meet with APPRMS to advise members of outcome of CG meetings, ratification of RVUs for core, non core and link items.
Deliverables	**NCCH**	Third Interim Report to MSRB - Board to approve work to date.

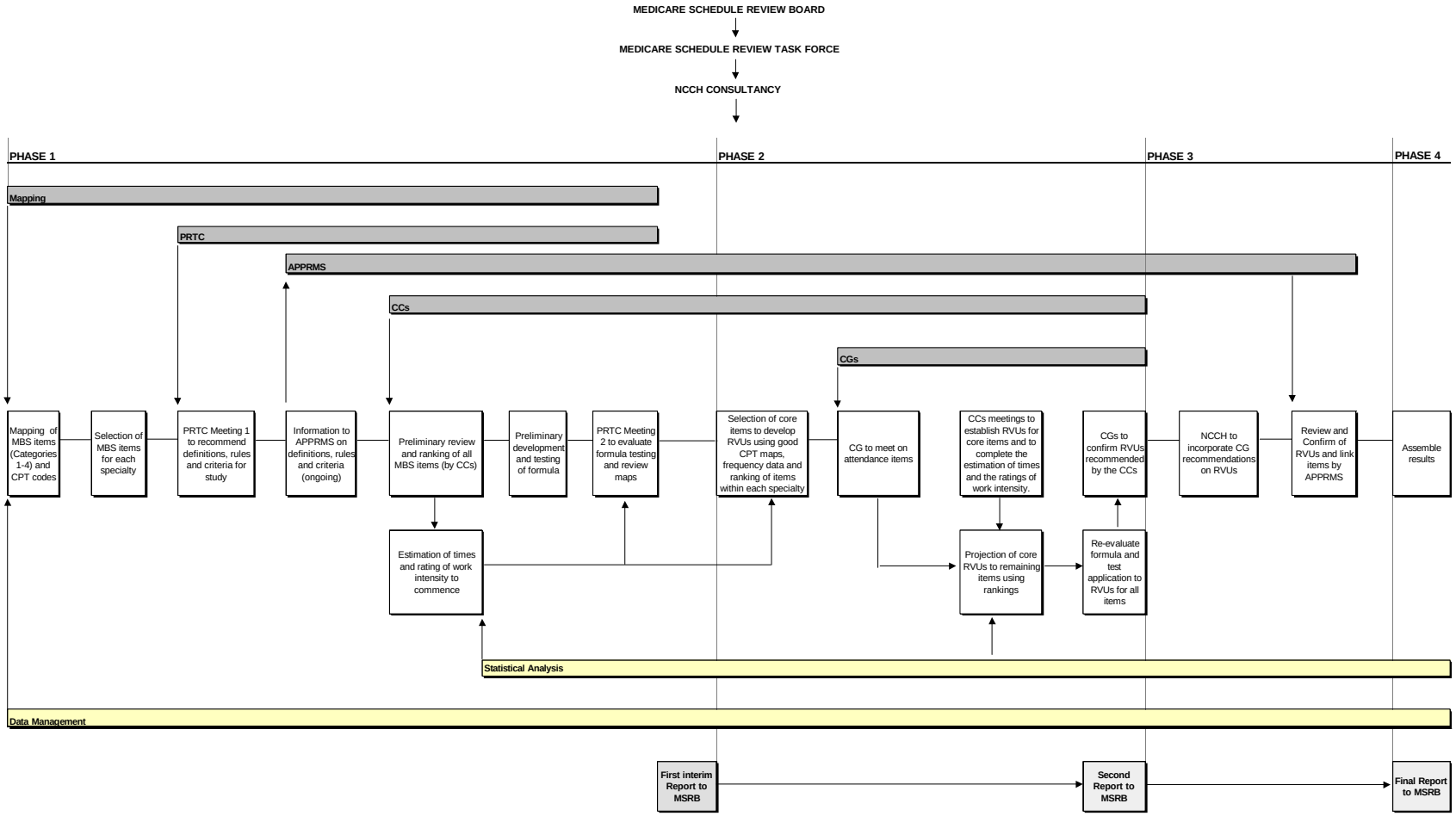
PHASE 4 - One month (June 1998)

Step 17	**NCCH**	Assemble results and prepare final report
Deliverables	**NCCH**	Final Report to MSRB

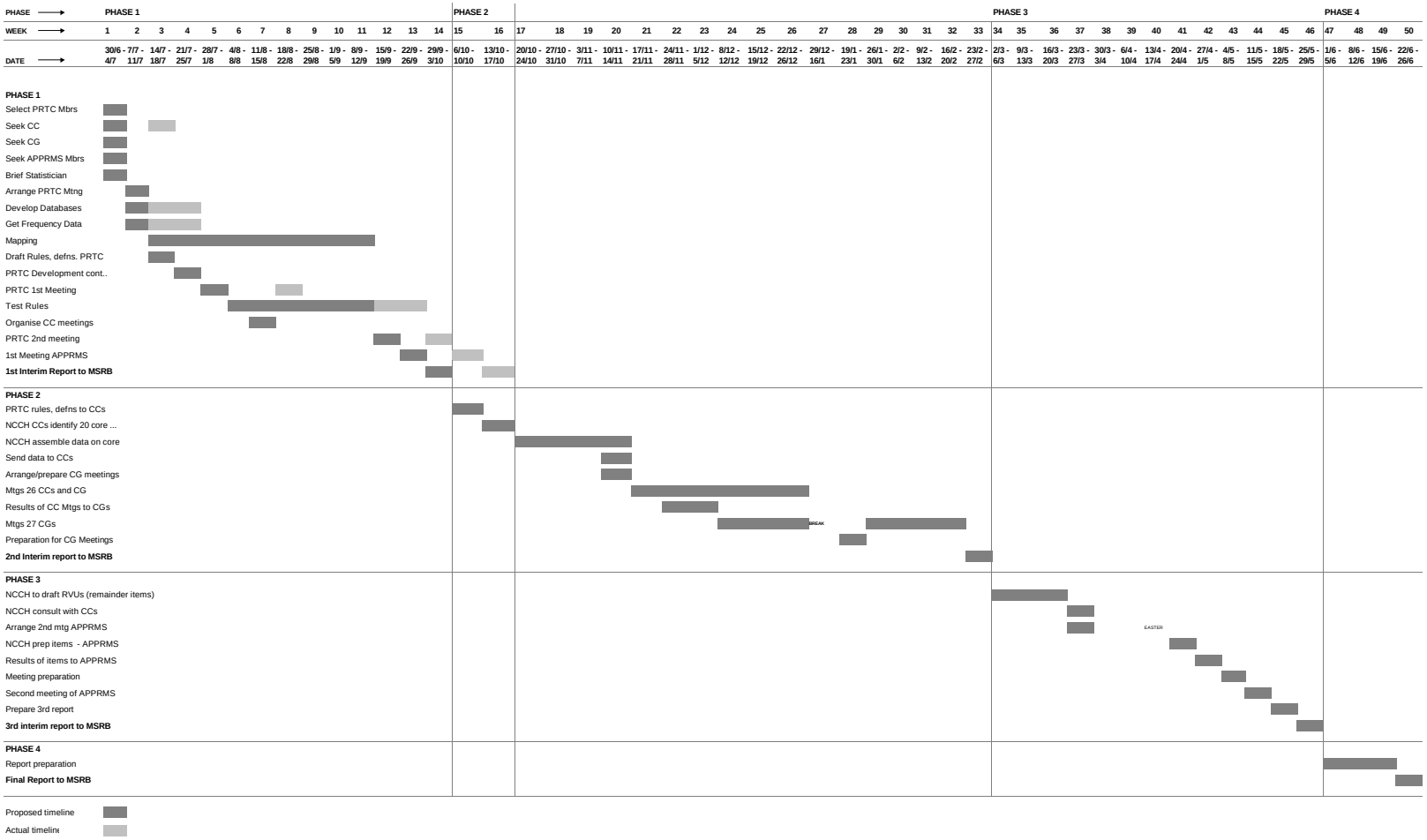
CATEGORIES OF MEDICAL PRACTITIONER APPROVED BY THE MEDICARE SCHEDULE REVIEW BOARD FOR PURPOSES OF THE PROFESSIONAL RELATIVITY AND PRACTICE COSTS STUDIES

1. Other Medical Practice
2. General Practice (vocationally registered)
3. Obstetrics and Gynaecology
4. General Surgery
5. Cardio-thoracic Surgery
6. Neurosurgery
7. Orthopaedic Surgery
8. Paediatric Surgery
9. Plastic Surgery
10. Urology
11. Vascular Surgery
12. Ophthalmology
13. ENT/Facio-maxillary Surgery (? Dental Surgery)
14. Anaesthesia (Specialist, Intensive Care, Resuscitation)
15. Dermatology
16. Psychiatry
17. General Medicine (Infectious Diseases, Geriatrics, Immunology, Endocrinology)
18. Cardiology
19. Renal Medicine
20. Gastroenterology
21. Neurology
22. Paediatric Medicine
23. Rehabilitation Medicine
24. Rheumatology
25. Thoracic Medicine
26. Emergency Medicine

PROFESSIONAL RELATIVITIES STUDY - OUTLINE OF PROCESSES



2.2 PRS - WORKPLAN



2.3 PROJECT MANAGEMENT AND COMMITTEE ROLES

Title	Members	Role
1. Project Management		
MSRB Medicare Schedule Review Board	DHSF: Dr Louise Morauta (Chairperson) Ms Gail Batman Dr Bill Coote Mr Terry Slater AMA: Dr Stephen Clarke Dr Bill Coote Dr Geoffrey Metz Dr Col Owen	Responsible for directing the Professional Relativities Study.
MSRTF Medicare Schedule Review Task Force	Mr Col Bailey Mr John Popplewell Mr David Reddy	Responsible for the management of the Professional Relativities Study
NCCH National Centre for Classification in Health		The NCCH is responsible for the day to day project management.
Director	A/Prof Rosemary Roberts	Attend meetings with MSRTF and MSRB. Assist with preparation of reports to MSRB. Liaise with members of MSRTF.
Project Manager Assistant Manager	Ms Lauren Jones Ms Sheelagh Noonan	Oversee the day to day management of the project for the NCCH. Become familiar with criteria, rules and definitions for development of RVUs. Communicate with MSRTF concerning organisation of meetings, preparation of data and reports to project groups and MSRTF. Supervise NCCH project officers. Ensure time lines are followed. Prepare interim and final reports for MSRB. Manage NCCH project budget. Attend meetings of PRTC, APPRMS, CCs and CGs when possible.
Meeting Facilitators	Ms Kay Bonello Ms Kerry Innes Ms Lauren Jones Ms Sheelagh Noonan A/Prof Rosemary Roberts Ms Sue Walker	Become familiar with criteria, rules and definitions for development of RVUs. Assist in preparation of material for CG meetings. Run CG meetings. Assist in preparation of reports from CG meetings.

Title	Members	Role
1. Project Management		
Project Officers	Ms Andrea Groom Ms Paula Hallang Ms Jennifer Shepheard Ms Joy Smith	Become familiar with criteria, rules and definitions for development of RVUs. Carry out mappings between MBS and CPT. Retrieve and assemble data on actual theatre times for Australian procedures, MBS relativities, CPT mapped item relativities and frequencies, anaesthesia times (in conjunction with MSRTF). Attend meetings of PRTC, APPRMS, CCs and CGs. Keep minutes and prepare reports of meetings.
Statistician OR Systems Pty Ltd	Mr George Rennie	Play a major role in PRTC in assisting with decisions on: definition of time - total service time, intra, pre and post, definition of direct/indirect time & effect on MBS relativities, effect of using existing MBS item relativities for RVUs, formula for calculating time and intensity to establish RVUs, methods for RVUs for consults, therapeutic and anaesthesia items, criteria for choosing core and link items, method for translating RVUs from core to remaining items, criteria for accepting a good map. Test PRTC decisions on above definitions and criteria. Supervise database manager. Attend meetings of PRTC, APPRMS. Liaise with NCCH and MSRTF.
Database Manager OR Systems Pty Ltd	Mr Andrew Brion	Prepare and maintain mapping data bases and reports. Prepare data bases with additional data on theatre & anaesthesia times, frequencies, MBS relativities. Enter results from CC and CG meetings on time and intensity estimates. Establish e-mail links with other project staff.
Administrative Assistant	Ms Ruth Rinot	Arrange meetings, travel. Disseminate material to meeting participants. Prepare reports. Liaise with interstate staff. Prepare and maintain data bases of group membership, contact addresses, phones, faxes, email. Liaise with MSRTF re meeting organisation.

2. Committees

Title	Members	Role
PRTC Professional Relativities Technical Committee 2 Meetings Phase 1	7 Clinicians: 1 GP rural 1 GP metropolitan 1 General Surgeon 1 Specialist Surgeon 1 General Physician or Paediatrician 1 Specialist Physician 1 Anaesthetist NCCH Director NCCH Project Manager Statistician Meeting Facilitators (5) MSRTF (3) MSRB (1)	Recommend definition of time - total service time, intra, pre and post. Recommend definition of direct/indirect time & effect on MBS relativities. Recommend effect of using existing MBS item relativities for RVUs. Recommend formula for calculating time and intensity to establish RVUs. Recommend methods for RVUs for consults, therapeutic & anaesthesia items. Recommend criteria for choosing core & link items. Recommend method for translating RVUs from core to remaining items. Recommend criteria for accepting a good map.
APPRMS Advisory Panel on Professional Relativities in Medical Services 2 Meetings Phase 1 Phase 3	26 Clinicians - 1 from each craft group NCCH Director NCCH Project Manager Statistician MSRTF staff MSRB members	Note and comment on PRTC rules, definitions, crtieria, formulae. Confirm RVUs for core and remaining items from CCs and CGs. Confirm link items. Provide communication to and from craft groups.
CCs Clinician Consultants 27 Meetings Phase 2	2 representatives of 26 specialties Attendance item Consensus Group NCCH Project Manager NCCH Project Officer	Decide 20 core items in specialty. Review data on core items. Establish times & intensity for core items. Establish link items. Make recommendations to Consensus Groups.

Title	Members	Role
2. Committees		
CGs Consensus Groups 27 Meetings Phase 2	Consensus Groups on Procedural Items: 26 groups representing procedural specialty groups 4 representatives of each specialty nominated by Colleges & Societies 2 clinician consultants NCCH Meeting Facilitator NCCH Project Officer 1 MSRTF representative Consensus Group on Attendance Items: 2 General Practitioners General Surgeon Specialist Surgeon General Physician or Paediatrician Specialist Physician (Cardiologist or GE) NCCH Meeting Facilitator NCCH Project Officer 1 MSRTF Representative	Agree RVUs for core items and confirm link items

3. Technical Working Papers

3.1	Study Definitions
3.2	Formulae for use in study
3.3	Criteria - good maps, core and link items
3.4	Methodology - for applying definitions, formula and criteria
3.5	Rules - parameters for study application

3. TECHNICAL WORKING PAPERS

Introduction

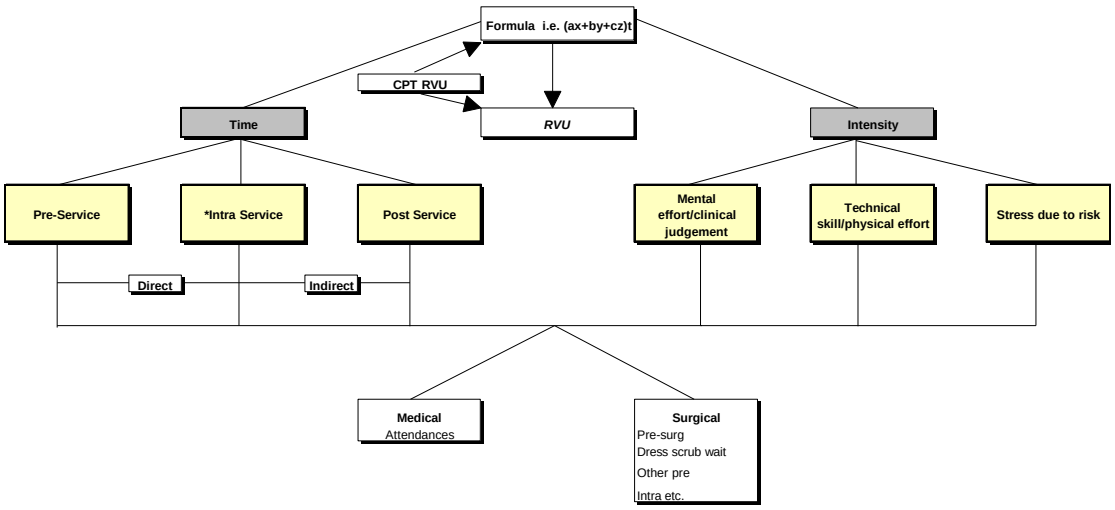
The role of the PRTC is to recommend definitions, rules and criteria for application throughout the study. The technical papers which follow set out:

- definitions to be recommended by the PRTC
- recommendation by the PRTC on components to be included in the formula
- criteria to be recommended by the PRTC for accepting a good map, choosing core items and link items
- methods recommended by the PRTC for RVU development, translation of core items to non core items, linking specialties and application of RVU already developed by Clinical Societies , Colleges and Associations
- rules or guidelines for the application of definitions, criteria and methods as recommended

A glossary of terms has been provided in section 4 to assist the PRTC in their deliberations.

Figure 3.1 below illustrates the primary components for the development of RVUs.

Figure 3.1
RVU Components



3.1 DEFINITIONS

	Definitions		Agenda Time
3.1.1	**Component**	**RVU Relative Value Unit**	
	Harvard Definition	The Unit of measure for the Medicare Resource-Based Relative Value Scale	
	PRTC Recommendation:		
3.1.2	**Component**	**Work**	
	Harvard Definition	Time and Intensity	
	PRTC Recommendation		
3.1.3	**Component**	**Time**	
	Harvard Definition	Total Service Time (Pre Service Time, Intra Service Time, Post Service Time) **Surgical work components (time)** - Pre-surg - Dress/scrub - Other pre - Intra Surgical - Post - ICU post - Other Post - Office Post Surgical	
	PRTC Recommendation:		

	Definitions		Agenda Time
3.1.4	**Component**	**Pre Service Time**	
	Harvard Definition	Initial Consultation up to Incision or Beginning of Service (*see also Glossary)*	
	PRTC Recommendation:		
3.1.5	**Component**	**Intra Service Time**	
	Harvard Definition	Evaluation and Management Services Face to Face Time with Patient Invasive Services Skin to Skin Contact (*see also Glossary)*	
	Other/Local Definition	Time between anaesthetist first approaching the patient to start the anaesthetic and when the patient leaves the operating theatre	
	PRTC Recommendation:		

	Definitions		Agenda Time
3.1.6	**Component**	**Post Service Time**	
	Harvard Definition	Closure or End of Service to follow up in Office (*see also Glossary)*	
	PRTC Recommendation:		
3.1.7	**Component**	**Direct Time**	
	Harvard Definition	Face to Face Patient Time	
	Local Definition	Face to face patient time for attendance items. Yet to be determined for other items.	
	PRTC Recommendation:		
3.1.8	**Component**	**Indirect Time**	
	Harvard Definition	Patient-Related Time (not face-to-face time)	
	Local Definition	Time spent by the doctor in connection with the item which is not direct time	
	PRTC Recommendation:		
3.1.9	**Component**	**Anaesthetic Time**	
	PRTC Recommendation:		

	Definitions		Agenda Time
3.1.10	**Component**	**Intensity**	
	Harvard Definition	Mental Effort & Clinical Judgement; Technical Skill & Physical Effort; Stress due to Risk ie Patient Risk & Difficulty of Procedure in Relationship to Risk	
	PRTC Recommendation:		
3.1.11	**Component**	**Mental Effort & Clinical Judgement**	
	PRTC Recommendation:		
3.1.12	**Component**	**Technical Skill & Physical Effort**	
	PRTC Recommendation:		

	Definitions		Agenda Time
3.1.13	**Component**	**Stress due to Risk** - Patient Risk - Difficulty of Procedure	
	PRTC Recommendation:		
3.1.14	**Component**	**Intensity: Pre and Post Service Time (if different to Intraservice Intensity)**	
	PRTC Recommendation:		
3.1.15	**Component**	**Linking Specialties**	
	Harvard Definition	Identifying Pairs (Links) of services from different Specialties that require approximately equal amounts of Intraservices Work	
	PRTC Recommendation:		

3.2 FORMULA FOR USE IN STUDY

Formula	Agenda Time

3.2.1 Estimating RVUs from times and intensities

This will be determined by regression analysis. It is anticipated that it will be a linear combination involving

- mental effort and clinical judgement
- technical skill and physical effort
- stress due to risk
- pre service time
- intra service time
- post service time

For example

a) $RVU = (ax + by + cz)t$

where x = mental effort and clinical judgement
y = technical skill and physical effort
z = stress due to risk
t = intra service time

and a, b, c represent the respective weights of x, y, z. These may or may not be equal.

PRTC Recommendation:

3.3 CRITERIA

Criteria **Agenda Time**

3.3.1 Criteria for accepting a good map

- Good terminology rating
- good code to code rating
- known relativity between pre, intra and post times for CPT and MBS

PRTC Recommendation:

3.3.2 Criteria for choosing core items

- high frequency
- good map
- good spread throughout ranking

PRTC Recommendation:

3.3.3 Criteria for choosing link items

- core items
- high frequency in both specialties

Note: if the same MBS item has been chosen as a core item in two specialties, then it will also be processed as a link item.

PRTC Recommendation:

3.4 METHOD

Methodology **Agenda Time**

3.4.1 Methods for RVU development, therapeutic & anaesthesia items

- based on CPT results, time estimates and intensity ratings for core items
- based on interpolation/extrapolation and formula for non core items

PRTC Recommendation:

3.4.2 Translating RVUs from core to remaining items

- to be done initially mostly by interpolation (with some extrapolation) based on the rankings provided by the clinical consultants. Later this will be revised using the final formula.

PRTC Recommendation:

Methodology	Agenda Time

3.4.3 Linking Specialties

Establish cross specialty procedures and pairs of procedures between specialties of similar relative value

PRTC Recommendation:

3.4.4 Scope of application of RVUs already developed by Clinical Societies, Associations and Colleges.

PRTC Recommendation:

3.5 OTHER

Item	PRTC Recommendations
3.5.1 Relativity of Attendance items to other items	
3.5.2	
3.5.3	

Item	PRTC Recommendations
3.5.4	
3.5.5	
3.5.6	

4. Other Documentation

4.1 Glossary of Terms

4.2 Specialty Groups - Items for review per specialty *(to be provided on 23/8/97)*

4.3 Other *(to be provided on 23/8/97)*

4.1 GLOSSARY OF TERMS

Consulting Groups (U.S. Definition)	Roles ? Guidance on study structure ? Guide on current state of medical practice ? Define work ? Comment on methods of measurement and their validity ? Advise on rating and ranking ? Advise on complexity of patient's condition ? Representations to four-man specialty panel to select equivalent services to link specialists into a common scale[1]
Core Item	Items to be selected for development of RVU estimates
Current Procedural Terminology	System for coding physician services developed by the American Medical Association to file claims with Medicare and other third-party payers; level 3 of the HCFA Common Procedure Coding System (HCPCS)[2] The CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians[3]
Direct Time (U.S. Definition)	Face to face patient time
(Local Definition)	Face-to face patient time for attendance items. Yet to be determined for other items
Extrapolation	Projection from known results to unknown cases where the unknown cases lie outside the range of the known cases
Indirect Time (U.S. Definition)	Patient-related time (not face to face)
(Local Definition)	Time spent by the doctor in connection with the item which is not direct time
Interpolation	Projection of known results to unknown cases where the unknown cases lie within the range of the known cases

Intensity (Local Definition)	Mental effort + clinical judgement Technical skill + physical effort Stress due to risk
Intra Service (U.S. Definition)	Evaluation + Management Services Face to face time with patient Invasive Services Skin to Skin contact[1]
(Local Definition)	Time between anaesthetist first approaching the patient to start the anaesthetic and when patient leaves the operating theatre
Linking Specialties	Identifying pairs (links) of services from different specialties that require approximate equal amounts of Intra Service work
Mapping	The term 'mapping' refers to the process of finding an 'equivalent' code between two classifications enabling interpretation of one classification to the other [4]
Physician Work (U.S. Definition)	The physician's individual effort in providing a service, which includes time, technical difficulty of the procedure, severity of patient's condition, and the physical and mental effort required to provide the service; one of three resource cost components included in the formula for computing payment amounts under the Medicare payment schedule amounts [2]
Post - Service Work (U.S. Definition)	
- Medical	Document observations, diagnosis + plans Communicating with other professionals, patients and relatives Assume responsibility for patients condition outside office and hospital Review records and write reports
- Surgical	Managing patients in ICU + other inpatient units Treating postoperative complications Review records and write reports

Post Service Time (U.S. Definition)	Closure or End Service up to follow-up visit in office
Pre + Post Operative Work (U.S. Definition)	$PPW = (PPT_{CS})\ (W/T)_{CS}$ PPW = Pre + post operative work PPT = Pre + post operative time W/T = Estimated work per unit time [1]
Pre - Service Work (U.S. Definition)	
- Medical	Reviewing patients records Communicating with other professional and/or relatives Preparation for particular services with staff [1]
- Surgical	Admitting patients to hospital Writing operative notes Pre-hospital visits Making diagnosis Discussing potential risks and benefits of surgery [1]
Pre Service (U.S. Definition)	Initial consultation up to incision or beginning of service [1]
Ranking	Placing items in order
Rating	Giving a score on a predetermined scale e.g. 1-10 or 1-100
Regression Analysis	Determination of the relationship between a dependent variable and a number of other variables (independent variables) by statistical means
Relative Value Scale (U.S. Definition)	An index of physicians' services ranked according to "value", with value defined according to the basis for the scale. In a charge-based relative value scale, services are ranked according to the average fee for the service or some other charge basis. A resource-based relative value scale ranks services according to the relative costs of the resources required to provide them.[2]
Remaining item	Non -core item

Resource Based Relative Value Scale (U.S. Definition)	A relative value scale based on the resource costs of providing physician services; adopted in OBRA 89 as the basis for physician payment for Medicare Part B services effective January 1, 1992. The relative value of each service is the sum of relative value units (RVUs) representing physician work, practice expense, and professional liability insurance (PLI) adjusted for each locality by a geographic adjustment factor and converted into dollar payment amounts by a conversion factor[2] i.e. RBRV = TW : PC : AST
Relative Value Unit (U.S. Definition)	The unit of measure for the Medicare Resource-Based Relative Value Scale The measure for the Medicare resource-based relative value scale. The relative value units must be multiplied by a dollar conversion factor to become payment accounts[2]
Time (U.S. Definition)	Pre Service Intra Service Post Service
Total work	Time + Intensity

[1] A National Study of Resource-Based Relative Value Scales for Physician Services - Harvard University 1992
[2] American Medical Association - Medicare RBRVS: The Physicians Guide - 1997
[3] American Medical Association - Physicians Current Procedural Terminology - 1997
[4] National Coding Centre - Coding Matters Vol. 2, No.4 April 1996

5. Literature

5.1 An Overview of the Development and Refinement of the Resource-Based Relative Value Scale
(Hsiao, W.C. et al, November 1992)

5.2 Assessing the implementation of physician-payment reform
(Hsiao, W.C. et al, 1 April 1995)

5.3 Valuing medical work
(Deeble, J.S, 1 July 1996)

5.4 The reliability and validity of work measurement in Australian general practice consultations
(Harris, E.A.et al, 1 July 1996)

Professional Relativities Study

Professional Relativities Technical Committee

Outcomes Report - Meeting No.1

Date: **Saturday 23 August 1997**

Venue: **Kingsford Room, Sydney Sheraton Airport Hotel**
Cnr O'Riordan and Robey Street, Mascot

Facilitator: **A/Prof Rosemary Roberts**

National Centre For Classification In Health

Professional Relativities Technical Committee (PRTC) Outcomes Report

The meeting was opened at 9.30 am by A/Prof Rosemary Roberts.

Present: As per list of Attendees (*see Attachment 5*)
Apologies: Mrs Sue Walker, National Centre for Classification in Heal th (NCCH) Queensland.

1. INTRODUCTION

1.1 Aims of the Day

A/Prof. Rosemary Roberts outlined the aims of the day. These included:

i an overview of the study methodology
ii an overview of the workplan and timeline
iii recommendations by the PRTC on:
- definitions
- criteria
- methods
- other study guidelines

iv review of division of specialty groups for the study
v calculation of weighted Relative Value Units (RVUs)

1.2 Guidelines for PRTC

John Popplewell spoke on the guidelines provid ed to the Professional Relativities Technical Committee (PRTC) in establishing ground rules for setting professional relativities.

It was explained that the Medicare Benefits Schedule would be the basis for the study. Only the professional work component of services would be addressed in this part of the study, with financial aspects of the study being undertaken by a separate consultancy examining remuneration issues. All services will have identifiable pre, intra and post service components, with expected variability in intensity within the "intra" components of many services, and that work is to be measured as a combination of time and intensity.

It was pointed out that the specialty Clinical Haematology should be included in the proposed specialty groups approved by the Medicare Schedule Review Board (MSRB). The NCCH will be recommending to the MSRB this and other groups be included in the study.

It was further recommended that "Sub-Specialties" within General Surgery, such as Colo-rectal and Upper Gastrointestinal need to be included in the study.

2. BACKGROUND TO THE PRS

2.1 Study Methodology and Workplan/Timeline

The NCCH clarified the stages of the Professional Relativities Study (PRS) methodology. This included mapping Medicare Benefits Schedule and the U.S. Current Procedural Terminology (MBS/CPT) items, ranking of items, estimates of time and intensity, formula development, choosing core and link items, development of Relative Value Units (RVUs) for core items (using CPT RVUs), projection of core RVUs, review and confirmation of RVUs.

The NCCH was asked by members of the PRTC to clarify its selection process for inviting Clinician Consultants (CCs) to be involved in the study. It was explained that many of the CCs were known to the NCCH from previous working arrangements. The PRTC requested that these names be circulated to the committee (*see Attachment 4*)

It was pointed out that during the study *consultations* should be considered in the same context as *procedures*.

Clarification was sought as to why the Australian study was being modelled on the Harvard US study. It was stated that the US study is the most developed of any comparable international attempt at a similar study.

The issue of specialty group representatives for the Consensus Groups (CGs) was discussed. The Medicare Schedule Review Task Force (MSRTF) have written to specialty Societies and groups requesting 4 representatives each for the study. The PRTC is to be informed of all specialty group representatives for the study.

2.2 Project Management and Committee Roles

The roles of the of the PRS committees were outlined.

The role of the PRTC is listed hereunder:

i Recommend definition of time - total service time intra, pre and post.
ii Discuss direct/indirect time and effect on MBS relativities.
iii Recommend effect of using existing MBS item relativities for RVUs.
iv Recommend formula for calculating time and intensity to establish RVUs.
v Recommend methods for RVUs for consultations, therapeutic and anaesthes ia items.
vi Recommend criteria for choosing core and link items.
vii Recommend method for translating RVUs from core to remaining items.
viii Recommend criteria for accepting a good map.

3. RECOMMENDATIONS BY THE PRTC

Recommendations were sought from the PRTC for the items listed in the following technical papers:

3.1 Study Definitions
3.2 Formula for Use in Study
3.3 Criteria - good maps, core and link items
3.4 Methodology - for applying definitions, formula criteria
3.5 Rules - parameters for study application

3.1 Study Definitions

The PRTC comments and recommendations on the definitions are detailed in table format - *see Attachment 1*. Work is to be measured as a combination of time and intensity.

3.2 Formula for Use in Study

A formula for the PRS will be developed using regression analysis. The PRTC confirmed that the following components of relativities should be considered for inclusion in the formula:

i pre-service time
ii intra-service time
iii post-service time
iv cognitive skills, clinical judgement and communication skills
v technical skill and physical effort
vi stress due to risk

3.3 Criteria

3.3.1 Criteria for accepting a good map

The NCCH explained that there were three criterion for accepting a "good map" ie correlation between Medicare Benefits Schedule (MBS) and the U.S. Current Procedural Terminology (CPT) items:

i Good terminology rating
ii Good code to code rating
iii Known relativity between pre, intra and post service times for CPT and MBS

PRTC Comments:

Members asked about the homogeneity of MBS items and CPT codes and the use of CPT frequencies for accepting a good map.

A draft spreadsheet for calculating weighted RVUs based on the CPT RVUs and frequencies was tabled. The members queried the use of all frequency data for mapped items. The statistician will provide advice on these calculations.

3.3.2 Criteria for choosing core items

The PRTC agreed that the criteria for choosing core items should be based on the following:

i high frequency
ii good map - *see 3.3.1*
iii good spread throughout MBS item rankings
iv at least one multi-specialty item (ie item being ranked by more than one specialty)
v clinical importance

PRTC Comments:

No objections were raised. However it was noted that criterion iv above would not always be possible.

3.3.3 Criteria for choosing link items

i core items
ii high frequency in both specialties

PRTC Comments:

A question was raised as to qualifying "high frequency". The statistician ad vised that in this context, high frequencies were relative to the distribution of MBS items within the speciality group.

It was agreed that the CPT RVU would be used as the benchmark for the link items between specialties.

The statistician explained that the RVUs would be used to test the formula, by analysing goodness-of-fit with time and intensity for each specialty.

3.4 Method

3.4.1 Methods for RVU development, therapeutic & anaesthesia items

i based on CPT results, time estimates and intensity ra tings for core items
ii based on interpolation/extrapolation and formula for non core items

PRTC Comments:

There was some concern about using United States (US) procedural times which are thought to be significantly longer than Australian procedural times. It was recommended that Australian times be used in the first instance and US times would be used to inform about differences in the RVUs.

3.4.2 Translating RVUs from core to remaining items

To be done initially mostly by interpolation (with some extrapolation) based on the rankings provided by the clinician consultants. Later this will be revised using the final formula.

PRTC Comments:

This involves projection from core items using interpolation (extrapolation) and information from time estimates and intensity items.

3.4.3 Linking Specialties

It was agreed that the study should address the establishment of cross specialty procedures and pairs of procedures between specialties of similar relative value. There was no further methodology established under this item.

3.4.4 Scope of application of RVUs already developed by Clinical Societies, Associations and Colleges.

The MSRTF has written to Colleges and craft groups for advice and information on any work undertaken in respect of relativities in their specialty crafts.

PRTC Comments:

It was advised that Anaesthetists already use relativities, based on intensity and time.

Members also commented that the specialist clinicians have been waiting for a standard for development of specialist relativities and that the PRS would address this gap.

Discussion was held concerning the difficulties in developing RVUs within the specialty groups, such as: distinguishing between referred and non-referred cases, opportunity cost of training. However, it was agreed that where specialties had already established RVUs, these could be of assistance when ranking and rating intensities.

3.5 Other

3.5.1 Relativity of Attendance items to other items

Given the recent changes to the Attendance items in the MBS and the crossover of the old item numbers across specialties, the PRTC was asked to recommend a strategy for developing attendance RVUs.

PRTC Recommendations

The PRTC agreed that the new structure for attendance items should be used for the PRS.

It was further recommended that

i each specialty group look at attendance items in conjunction with the procedural items

ii a different method be used for allocation of Attendance items to specialties for the rating of intensity

iii the Consensus Group for Attendances should meet earlier than planned in order to make recommendations to the specialty groups for the comparison of procedure and attendance items.

3.5.2 Criteria for assigning MBS items to Specialty craft groups

Two sets of preliminary analyses of MBS data will be used to assign items to specialty groups. Firstly, items used by each specialty group will be analysed. Secondly, a review of all items by service providers will be undertaken to ensure that the specialty providing the majority of services per item is included wherever practicable. In some instances a specialty may be responsible for a small percentage of the total frequency for a particular item number yet the same item number may represent a significant number of that specialty's total work.

For example: *MBS item 50124 (Joint or other Synovial Cavity aspiration injection of...) has the highest usage for Orthopaedic and General Practice Specialty groups. However, it represents 95% of the usage of procedural items by Rheumatologists.*

The statistician recommended that any item be given a maximum of 2 specialties for ranking and rating. This would minimise:

i the analysis of rankings and ratings per specialty, and
ii the time needed for analysis of link items.

It was further recommended that the frequency distribution per specialty should be used to allocate MBS items to specialties as opposed to pure frequencies.

PRTC Recommendations:

It was recommended that:

i When selecting items for a group, MBS items will f irst be allocated to the specialty to which the item represents the highest proportion of items performed by that specialty.

ii Secondly, items will be allocated to a specialty if the specialty provides a high percentage of services for the MBS item.

iii Where a specialty has 100% of an item, (ie service provision) it should review the item regardless of the frequency distribution within that specialty.

iv If GPs provide greater than 50%, they should be included for reviewing item.

v If GPs are doing greater than 30%, they should be considered for reviewing item.

Subsequent to the draft PRTC Outcomes Report, MBS items have been assigned to specialty groups. *Attachment 2* outlines the specific criteria used for item selection based on the above recommendations.

4. OTHER BUSINESS

The PRTC requested that the following information be provided to the committee:

1. Abbreviations relating to all components of the study - *see Attachment 3*

2. Names of the NCCH Clinician Consultants - *see Attachment 4*

3. Membership of all CGs - to be forwarded at a later date

Attachments

1. Definitions for the PRS
2. Criteria for MBS Item selection
3. Abbreviations for PRS
4. Names of NCCH Clinician Consultants
5. List of Attendees

PROFESSIONAL RELATIVITIES TECHNICAL COMMITTEE

DEFINITIONS

Component	Definition
1. RVU - RELATIVE VALUE UNIT	
PRTC Recommendation:	The unit of measure for the professional work component in the Relative Value Study.
2. WORK	
PRTC Recommendation:	Time and Intensity.
3. TIME	
PRTC Recommendation:	**Total service time.** Incorporates both patient related (face to face) and (non face to face) direct and indirect time.
PRTC Comments:	The members discussed the elements of *direct* (time with patient) and *indirect* time (time without patient) and *family* time.
4. PRE SERVICE TIME	
PRTC Recommendation:	Time taken to prepare for a specific service.
PRTC Comments:	It was noted that Rural medicine and anaesthetics may be an exception to the definitions also that service time (pre/intra/post) would be different for procedures as opposed to consultations. It was thought that *pre-service time for procedures* might be defined as *"the patient related time up until the procedure, excluding any consultation item time"*. However, the definition above was tentatively agreed upon as it was more generic describing both procedures and consultations. *Note: for procedures includes dress, scrub and wait*.

Component		Definition
5.	**INTRA SERVICE TIME**	
	PRTC Recommendation:	For procedures: Time in which the service provider is in direct contact with the patient in the procedure room. *Note: for most procedures this would be 'skin to skin' time ie. opening to closing. For others it would include positioning of the patient.* For consultations: Face to face time with the patient (excluding pre-service time).
6.	**POST SERVICE TIME**	
	PRTC Recommendation:	For procedures: Closure or end of service to completion of normal "after care". *Note: includes recovery, ICU, CCU.* For consultations: Time spent on specific service after cessation of face to face contact.
7.	**DIRECT TIME**	
	PRTC Recommendation:	Face to face time with patient. *Note: not used for the PRS*
8.	**INDIRECT TIME**	
	PRTC Recommendation:	Non face-to-face patient related time *Note: not used for the PRS*
9.	**ANAESTHETIC TIME**	
	PRTC Recommendation:	Anaesthetic Time begins when the anaesthetist begins to prepare the patient for anaesthesia care in the operating room or in an equivalent area and ends when the anaesthetist is no longer in personal attendance, that is, when the patient may be safely placed under the supervision of other personnel. (Definition agreed upon by the AMA, Dept. of Health and Australian Society of Anaesthetists.)
10.	**INTENSITY**	
	PRTC Recommendation:	i cognitive skill, clinical judgement & communication skills ii technical skill & physical effort iii stress due to risk
11.	**COGNITIVE SKILL & CLINICAL JUDGEMENT & COMMUNICATION**	

Component	Definition
SKILLS	
PRTC Recommendation:	Cognitive skill, clinical judgement and communication skills ✍ *Rated only for "intra service" time, with an average taken for pre and post service times.*
12. TECHNICAL SKILL & PHYSICAL EFFORT	
PRTC Recommendation:	Technical skill & physical effort ✍ *Rated only for "intra service" time, with an average taken for pre and post service times.*
13. STRESS DUE TO RISK	
PRTC Recommendation:	Stress due to risk to patient and/or difficulty of procedure ✍ *Rated only for "intra service" time, with an average taken for pre and post service times.*
14. LINKING SPECIALTIES	
PRTC Recommendation:	Where the same procedure is carried out by different specialties or the items are of equal professional work
PRTC Comments:	The PRTC agreed that two approaches for data linking are possible: i MBS items carried out by different specialties. ii linking different item numbers

✍ *Consultant physicians offered to rate intensities post-service as well as intra-service. If this is done the corresponding data could be included in the analysis.*

Criteria for MBS Item selection - PRS

1 Provided the specialty had performed a sufficient number of services (>3 and >12.5% of the total services), MBS items were first allocated to the specialty which provided most services for the item in proportion to the total number of services provided by that specialty (*PRTC criteria 1*)

2 Items were allocated to a second specialty if the item constituted more than 0.1% of the specialty's workload, the specialty provided more than 25% of the total services for the item, no other eligible speciality provided more services and the item had not already been allocated to the specialty under 1 (*PRTC criteria 2-5*)

3 Items were also allocated if the specialty performed the second most services (these being >3, >12.5% of total services and >0.1% of the services provided by the specialty) for the item in proportion to the total number of services provided by the specialty, and the item was not already allocated under (2) (*PRTC criteria 1*)

4 Where there were insufficient claims data to make an initial allocation according to statistical rules, items were allocated manually to a single specialty on the basis of the location in the schedule or in accordance with the allocation of similar items (*PRTC criteria 3 considered)*

An exception report of major providers who missed out on allocation was produced and reviewed and submitted to the Task Force. This will assist with the manual allocation of items.

ABBREVIATIONS

APPRMS	Advisory Panel on Professional Relativities in Medical Services
CCs	Clinician Consultants
CGs	Consensus Groups
CPT	Current Procedural Terminology (American Medical Association)
DHFS	Department of Health and Family Services
MBS	Medicare Benefits Schedule
MSRB	Medicare Schedule Review Board
MSRTF	Medicare Schedule Review Task Force
NCCH	National Centre for Classification in Health
PRS	Professional Relativities Study
PRTC	Professional Relativities Technical Committee
RBRV	Resource Based Relative Value
RBRVS	Resource Based Relative Value Scale
RVU	Relative Value Unit

Professional Relativities Study

Clinician Consultants

	SPECIALTY GROUP	NAME	LOCATION
1	General Practice	**YTD**	
	Emergency Medicine	Dr Michael Cleary	Brisbane
2	Facio-max surg	Dr Mark Moore	Adelaide
3	Obstetrics and Gynaecology	Dr Miriam O'Connor Prof Roger Pepperell	Melbourne Melbourne
4	General surgery	Mr John Cocks Dr Peter Burke	Melbourne Sydney
	- Breast	Dr Michael Henderson	Melbourne
	- Colorectal	Mr Ian Jones	Melbourne
	- Upper GI	Dr Christopher Worthley	Adelaide
5	Cardio-thoracic surgery	Dr Brian McCaughan	Sydney
6	Neurosurgery	Mr Peter Bentivoglio Mr Graeme Brazenor Mr Richard Vaughan	Sydney Melbourne Sydney
7	Orthopaedic surgery	Dr Philip McGrath	Sydney
8	Paediatric surgery	Dr Hugh Martin	Sydney
9	Plastic surgery (Reconstructive, Hand)	Mr Frank Ham Mr Bruce Johnstone	Melbourne Melbourne
	- Burns	Dr Peter Kennedy	Sydney
10	Urology	Mr Laurie Cleeve Mr DG Travis	Melbourne Melbourne
11	Vascular surgery	**YTD**	
12	Ophthalmology	Dr Michael Hennessy Dr Justin Playfair	Sydney Sydney
14	Anaesthesia - Specialist	Prof Bill Runciman	Adelaide
	Anaesthesia - Hyperbaric	Dr Michael Bennett	Sydney
15	Dermatology	Dr Robert Salmon	Wollongong
16	Psychiatry	Dr Kay Wilhelm	Sydney

17	General medicine - Infectious diseases - Geriatrics - Endocrinology	Dr Peter Greenberg Dr Phillip Jones Dr Terence Finnegan Dr Duncan Topliss	Melbourne Sydney Sydney Melbourne
18	Cardiology	Dr Terry Campbell	Sydney
19	Renal medicine	Dr Lindsay Barratt Dr Timothy Mathew	Adelaide Adelaide
20	Gastroenterology	Dr Finlay Macrae	Melbourne
21	Neurology	Dr Robert Hjorth	Melbourne
22	Paediatric medicine	Dr Ralph Hanson	Sydney
23	Rehabilitation medicine	Dr Lynette Lee	Sydney
24	Rheumatology	Dr David Barraclough	Melbourne
25	Thoracic medicine	Dr Chris Clarke	Sydney
26	IVF	Dr Geoffrey Driscoll	Sydney
27	Radiation oncology	Dr David Thomas	Brisbane
28	Clinical haematology	Dr Frank Firkin	Melbourne
29	Medical oncology	Dr Raymond Snyder	Melbourne
30	Intensive care	Dr Robert Herkes	Sydney
31	Nuclear medicine	Dr Barry Chatterton	Adelaide
32	Immunology	**YTD**	

Professional Relativities Study

Professional Relativities Technical Committee

ATTENDEES

Clinical Members

Dr Robert ALLAN
General Practitioner

Dr Robert BLACK
General Surgeon

Dr G Patrick BRIDGER
ENT Surgeon

Dr Greg DEACON
Anaesthetist

Dr Paul DUGDALE
General Practitioner

Dr Finlay MACRAE
Gastroenterologist

Dr Michael RICE
Paediatrician

Medicare Schedule Review Board

Dr Stephen CLARKE
Australian Medical Association

National Centre for Classification in Health:

Ms Barbara ANDERSON
Meeting Facilitator

Ms Kay BONELLO
Meeting Facilitator

Ms Patricia DAHDAH
Specialty Group Analysis

Ms Kerry INNES
Assoc. Director (Meeting Facilitator)

Ms Lauren JONES
Project Manager

Ms Sheelagh NOONAN
Assistant Project Manager

Mr George RENNIE
Statistician (OR Systems P/L)

A/Prof. Rosemary ROBERTS
Director (Convenor - PRTC)

Medicare Schedule Review Task Force:

Mr Col BAILEY
Mr John POPPLEWELL
Mr David REDDY