



Eye injection treatment costs and rebates

This fact sheet provides general information on the bill you receive from your ophthalmologist for eye injections for the management of wet macular degeneration, diabetic retinopathy and similar conditions. It also gives some general information on your entitlements from Medicare.

As ophthalmologists are entitled to set their own fees, this fact sheet cannot provide specific information or precise rebates for your individual situation. You should ask your ophthalmologist for written details on the fees and charges you will incur for consultations, tests and treatment. If the costs are going to place you under financial difficulty and possibly compromise your treatment plan, you should discuss this with your doctor.

The fees you pay may involve up to four areas: consultation, diagnostic tests, drug costs and injection costs. In some cases (especially for diabetic retinopathy), you may also be billed for laser treatment. Doctors may list and describe the items and cost on the bill in varying ways. The Foundation has highlighted in **blue bold** throughout the factsheet the Medicare item numbers and descriptors that may most likely be used.

In this fact sheet the term 'doctor' means the ophthalmologist.

Consultations

Medicare item 104 - Initial consultation: This item applies when you first visit the doctor for a specific condition.

Medicare item 105 - Subsequent consultation: This item applies for ongoing consultations.

Diagnostic tests

a) Fundus fluorescein angiography (also known as angiogram or FFA)

Medicare item 11215 (one eye) or item 11218 (two eyes) - Retinal photography, including intravenous dye examination

This test checks for bleeding or leakage under the retina. It is required before you first start injections in order to qualify for Pharmaceutical Benefits Scheme (PBS) reimbursement of the drug that is used to treat the bleeding or leakage. It may also be done to check for new leakage.

b) Ocular coherence tomography (OCT): **Medicare item 11219**

An OCT scan shows the cross-sectional layers of the retina and is initially performed to confirm a diagnosis and measure how much swelling has occurred. OCT scans will typically be undertaken on a regular basis while on a course of injections in order to monitor response to treatment. OCT scans are now internationally recognised as the standard of care to monitor response to injections. From November 2016, up to one OCT scan per year may be reimbursed by Medicare, but only when the scan is performed by an ophthalmologist for an initial diagnosis to confirm eligibility for PBS-funded eye injections. OCT scans for ongoing monitoring of disease are not currently reimbursed by Medicare.

c) **Other tests:** Depending on individual needs, other tests may be undertaken.

Drug costs

The cost of the drug is in addition to the diagnostic and injection fees.

a) Lucentis and Eylea

The drugs Lucentis and Eylea are registered by the Therapeutic Goods Administration (TGA) and are subsidised by the Pharmaceutical Benefits Scheme (PBS) for the treatment of:

- Wet age-related macular degeneration (AMD)
- Diabetic macula edema (DME)
- Retinal vein occlusion (RVO)

Under the PBS, the subsidised cost of these drugs in 2017 per prescription (1 dose) is:

- \$6.30 (concession card holder); or
- \$38.80 (non-concession)

The PBS Safety Net will apply once the costs in a calendar year for all PBS drugs exceed \$378.00 (concession) or \$1,494.90 (non-concession). After reaching the PBS Safety Net, each subsequent PBS script will be free (concession) or \$6.30 (non-concession) for the remainder of the calendar year.

b) Avastin

For those who do not qualify for PBS subsidised drugs, the drug Avastin may be used. Avastin is not registered by the TGA for use in the eye. This is known as “off-label” use and it is not subsidised by the PBS for these conditions. The cost of Avastin typically ranges between \$50 and \$80 per dose.

Treatment procedures

Injection procedure

Either of two Medicare items may be used for the injection procedure.

Medicare item 42738 – Intra-vitreous injection: This may appear on the bill as “Paracentesis” or “Injection”.

Medicare item 42739 – Intra-vitreous injection: This item number will be used if you require sedation or a general anaesthetic, where an anaesthetist is present. This may also appear on your bill as “Paracentesis” or “Injection”.

Laser procedure

In some cases, laser treatment may be used.

Medicare item 42809 - Retina photocoagulation

Medicare benefits

Medicare provides significant benefits (rebates) for many of the items related to eye injections. The benefit is normally paid:

- in doctors' rooms: as 85% of the 'schedule fee'
- in a private hospital or day case setting: as 75% of the 'schedule fee'

Table 1: Current Medicare Benefits

Item	Description	Schedule fee	85% benefit (in-rooms)	75% benefit (private hospital)
104	Initial consultation	\$85.55	\$72.75	\$64.20
105	Subsequent consultation	\$43.00	\$36.55	\$32.25
11215	Angiogram (one eye)	\$123.00	\$104.55	\$92.25
11218	Angiogram (two eyes)	\$151.75	\$129.20	\$114.00
11219	Optical coherence tomography (OCT) (initial diagnosis only)	\$40.00	\$34.00	\$30.00
42738	Injection fee	\$300.75	\$255.65	\$225.60
42739	Injection w/ sedation/anaesthetic	\$300.75	\$255.65	\$225.60
42809	Retina photocoagulation (laser)	\$451.10	\$383.45	\$338.35

Note:

- For injections in both eyes on the same day, the benefit for the second eye is reduced by 50%. If two eyes are treated on separate days, the normal benefits apply.
- OCT scans will only be reimbursed for an initial diagnosis to confirm eligibility for PBS-funded eye injections, with a maximum of one reimbursement per year.

Original Medicare Safety Net

The difference between the schedule fee and the benefit paid by Medicare is known as the 'gap amount'.

The 'gap amount' for an eye injection given in the doctor's rooms is currently **\$45.10**. This is calculated as the schedule fee (\$300.75) minus Medicare benefit (\$255.65).

(Refer to Table 1)

Once the total gap amount for all Medicare items exceeds the Original Medicare Safety Net threshold* in a calendar year, the Original Medicare Safety Net will refund 100% of the schedule fee for subsequent Medicare items. For example, for **Item 42738 (Injection fee)**, you would receive a benefit of \$300.75.

* The Original Medicare Safety Net threshold is set by the Australian Government and changes from time to time. In 2017 the threshold is \$453.20.

Out-of-pocket costs

Doctors may charge more than the Medicare schedule fee. The difference between what the doctor charges and the Medicare benefit is known as the 'out-of-pocket' cost. This is different to the 'gap amount'.

Example:

Note: Costs vary between doctors. The following is an example only.

If a doctor charges \$100 for a subsequent consultation (Item 105) and \$400 for an in-rooms injection (Item 42738), the out-of-pocket costs for these will be as follows (in red):

Table 2: Example of out-of-pocket costs

Service	Item	Ophthal charge (a)	Schedule fee (b)	Medicare benefit (c) (85% of (b))	Out of pocket cost per visit (a)-(c)
Subsequent consultation fee	105	\$100.00	\$43.00	\$36.55	\$63.45
Injection fee	42738	\$400.00	\$300.75	\$255.65	\$144.35
		\$500.00		\$292.20	\$207.80

If the Original Medicare Safety Net has also been reached, the out-of-pocket costs would be further reduced.

Extended Medicare Safety Net

Once the total out-of-pocket costs for all **non-hospital** Medicare items exceed a certain threshold⁺ in a calendar year, the Extended Medicare Safety Net (EMSN) will refund the relevant Medicare benefit PLUS a further benefit of 80% of out-of-pocket costs for Medicare items.

⁺ The Extended Medicare Safety Net thresholds are set by the Australian Government and change from time to time. In 2017, the thresholds for out-of-pocket costs are:

- Concession card holders: \$656.30
- Non-concession: \$2,056.30

Example:

Using the same charges as Table 2, once the EMSN threshold has been reached, the total benefit paid for the injection (Item 42738) would equal the normal Medicare benefit of \$255.65 plus the EMSN benefit of \$115.50 (being 80% of the out-of-pocket amount of \$144.35), giving a total benefit of \$371.15. This means you would only pay \$28.85 for that item after you have received all the rebates.

Table 3: Example of benefits and out-of-pocket costs that may apply once the EMSN threshold has been reached

Service	Item	Ophthal charge (a)	Medicare benefit (b)	OOP costs before EMSN threshold (c) (a-b)	EMSN benefit (80% of OOP costs) (d) (80% of (c))	Out-of-pocket costs after reaching Extended Medicare Safety Net threshold (a)-(b)-(d)	
Subsequent consultation fee	105	\$100.00	\$36.55	\$63.45	\$50.75	\$12.70	(20% of OOP)
Injection fee	42738	\$400.00	\$255.65	\$144.35	\$115.50	\$28.85	(20% of OOP)
		\$500.00		\$207.80	\$166.25	\$41.55	

(OOP = out of pocket)

If the Original Medicare Safety Net had also been reached, the benefits would be slightly higher.

For some procedures, including eye injections, the EMSN benefits are capped.

Note:

- Other than when used for an initial diagnosis to confirm eligibility for PBS-funded injections, OCT scans do not attract any Medicare benefits and do not contribute towards the Original or Extended Medicare Safety Net threshold.
- Procedures performed in a private hospital or day surgery setting do not contribute towards the EMSN threshold and do not receive the additional 80% EMSN benefits.

Registration for Medicare Safety Net

Couples and families need to register as a Medicare Safety Net family, even if all are listed on the same Medicare card. Medicare will automatically keep a total of your gap amounts and out-of-pocket medical expenses. Registration is free and you only need to register once in your lifetime.

To register for the Medicare Safety Net:

- Download a Medicare Safety Net couples and families registration and amendment form from www.humanservices.gov.au
- Visit your local Medicare office
- Call Medicare 132 011

Department of Veterans' Affairs (DVA) patients

DVA gold card holders may qualify for some additional rebates, including additional OCT scans.

Treatment in hospital

Treatment in public hospitals

A limited number of public hospitals provide outpatient treatment for conditions including macular degeneration and diabetic retinopathy. There should be no charge for treatment and diagnostic tests, although in some states, there may be a requirement to pay the PBS co-contribution if Lucentis or Eylea are used (\$6.30 concession or \$38.80 non-concession).

Treatment in private hospitals

In some situations, a doctor may decide to give injections in a private hospital or day surgery setting. People who hold private health insurance may be able to claim from their private health fund for the procedure and accommodation charge. This is dependent on the insurer and the policy.

Important points

- Injections are typically required for an extended period (many years), and possibly for life.
- You should obtain a written estimate of fees, Medicare benefits and out-of-pocket costs from your doctor.
- If you have financial difficulty with treatment costs, discuss your concerns with your doctor or the appointed person in the practice.
- Treatment should not be stopped without discussion with the doctor. There may be a number of challenges with maintaining treatment, including costs or transport or other health issues.
- Discuss your concerns with your doctor.

If you require further information, clarification or guidance on eye injection treatment and benefits or related matters please contact:



Our focus is your vision

Macular Disease Foundation Australia

Suite 902, 447 Kent St

Sydney NSW 2000

Phone: 1800 111 709

Email: info@mdfoundation.com.au

Web: www.mdfoundation.com.au

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