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SUBMISSION

Closes Wednesday, 14 August 2024

AMA submission to MSAC – new Cardiac MRI MBS item

By email: msac.secretariat@health.gov.au

Introduction

Thank you for providing the opportunity to review and contribute comment on the determination to create a new diagnostic imaging item based on the recommendations from MSAC in April 2024.

The AMA is pleased to note the in-depth review the department has given to the Cardiac Society of Australia and New Zealand's (CSANZ) proposal 1713, which made the case for the listing of a cardiac magnetic resonance imaging (MRI) item for the diagnosis of myocarditis.

This proposal is timely, with patient access to temporary item 63399 for cardiac MRI for mRNA-associated myocarditis due to cease in December 2024. While use of this item is in decline, the provision of cardiac MRI services bears a relationship with patients requiring access to the COVID-19 vaccine claims scheme.

It is concerning that under the current arrangements, patients are typically diagnosed only with suspected myocarditis based upon symptoms, signs and other cardiac tests because the more thorough and complex endomyocardial biopsy test (EMB) capable of diagnosing the condition is not easily accessible. This is sufficient justification for providing permanent MBS-supported access to alternative myocarditis diagnostic services that support better patient outcomes.

1. Benefits to retaining patient access to cardiac MRI

Although based upon general evidence, we support the clinical claim that cardiac MRI is preferable to an EMB for diagnosis of MRI, based upon superior myocarditis diagnostic accuracy and a less invasive procedure. Greater accessibility to an MRI will promote earlier detection and better health outcomes for patients with suspected myocarditis and signs and symptoms of acute onset cardiomyopathy (proposed Population 1).

The AMA acknowledges MSAC's recommendation to exclude Population 2 from eligibility to a cardiac MRI item, given patients in this cohort will still be directed to undergo coronary imaging after accessing an MRI to rule out obstruction. This is an appropriate caution in response to clinical evidence that cardio MRI will always be an adjunct service rather than a replacement.

Under the same rationale, the AMA would also be supportive of including access to this second cohort in line with clinical advice documented in the consultation. The Society for Cardiovascular Magnetic Resonance (SCMR) suggested Population 2 could be redefined within the service scope for the

purpose of adequate clinical workup to exclude those patients who have undergone initial investigation with negative or equivocal indicators, e.g. moderate-high likelihood of acute coronary syndrome (ACS). Clinical advice would suggest these patients should be considered for cardiac MRI prior to ischemia work up, which may obviate the need for invasive testing in some cases.

2. Support for clinical advice regarding cardiac MRI

The AMA acknowledges the decision to use linked evidence to cardiac MRI in this report, given the absence of direct evidence for health outcomes. It is the AMA's position that sound clinical advice should be the key determinant of service design and the provision of government support through the MBS.

The AMA supports the MSAC's indicated fee structure alike to similar MRI MBS items, noting a cardiac MRI procedure is a less intensive service than comparable MRI procedures and may not require equal remuneration to the temporary MBS item 63399. CSANZ's application also acknowledged this may be the most reasonable approach.

The AMA is broadly supportive of the recommendations to ensure access to cardiac MRI is supported after the cessation of the temporary item, where appropriate and clinically prudent.

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