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MBS Review Clinical Committee reports – Colorectal, General, Plastic and Reconstructive, Vascular and Thoracic surgery

AMA submission to the MBS Review Taskforce

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Introduction

Five MBS Review surgical reports—Colorectal, General, Plastic and Reconstructive, Vascular and Thoracic Surgery, were released in late 2018 and February 2019, for stakeholder feedback.

Whilst the AMA submitted a response to the MBS Review Plastic and Reconstructive Clinical Committee report on 9 April 2019, this report is included in this submission as it relates to the maximum three item restriction on T8 Surgical items.

The AMA has consulted with its members, Councillors, the Royal Australian and New Zealand College of Radiologists (RANZCR), the Australian and New Zealand Society of Vascular Surgery (ANZSVS) and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) in preparing this submission.

This submission provides AMA's overarching response to the MBS Review Clinical Committees' recommendations to reduce inappropriate co-claiming of T8 surgical operations items— most significantly the proposed maximum 3 item restriction.

The AMA also provides specific responses to the General Surgery and Vascular Clinical Committee reports.

Key points

The AMA:

- Strongly opposes the proposed maximum 3 item restriction on T8 surgical operations items.
- Urges the Taskforce to work closely with the relevant specialty groups to determine or confirm the appropriate fee for the newly combined or additional MBS items that are recommended to reduce inappropriate co-claiming.
- Supports the acute wound care fee increase recommended in the General Surgery CC report.
- Opposes Recommendation 3 of the Vascular CC report for specialist referral of renal doppler ultrasound.
- Urges the Taskforce to work with the relevant craft groups to revise the funding model for angiography (VCC report) to ensure reflection of true cost of providing the service and viability in the private setting.

Inappropriate co-claiming of T8 surgical operations items

The AMA notes that several mechanisms have been proposed by the various surgical clinical committees to address inappropriate co-claiming and these include:

1. Combining frequently co-claimed items or items with low service volume, to reflect a complete service and adjust the relative reimbursement accordingly;
2. Creating new items for procedures where currently multiple items are claimed for the one procedure; and
3. Placing maximum 3 item restrictions on other T8 items for a single procedure or episode of care.

<u>Combining of like-procedures</u>

With respect to the first and second mechanisms listed above, the AMA agrees with the general principle behind combining frequently co-claimed items that are part of a single procedure. In particular, the AMA agrees with combining all like-procedures that are currently separated by means of access (eg laparoscopic and open (laparotomy) techniques) in circumstances where there is no significant difference in the magnitude or the complexity of the procedure by laparotomy or laparoscopic approach. However, the AMA urges the Taskforce and Clinical Committees to work closely with the relevant specialty groups to determine or confirm the appropriateness of the combined items and the fee for the revised items to minimise unintended consequences of reduced patient rebates and increased out of pocket costs.

<u>Maximum Three Item restriction</u>

Restriction is heavy handed and inappropriate

In assessing the proposed maximum three item rule, the AMA revisited the rationale for the proposed restriction provided in the Final First Report of the MBS Principles and Rules Committee (2016), where this recommendation originated. It is disconcerting that the PRC report (page12) infers that the root cause of inappropriate co-claiming is doctors' 'gaming' of the system:

> *"An argument used to support claiming a higher number of services than might seem appropriate is that patients benefit from the higher total of Medicare benefits they accrue. Firstly, the 'gaming' of the MBS for any purpose—even the ostensible benefit of patients—is inappropriate."*

Table 3 of the PRC report—Benefits paid for 4 or more items by derived specialty for surgical procedures (Category 3 – Group T8), reports that 26 to 39 per cent of cardio-thoracic, neurosurgical and urogynaecology surgeons are co-claiming more than three items in one episode of care. The AMA rejects the notion that a significant proportion of the 26-39 per cent of these co-claims are due to surgeons 'gaming the system'. The data suggests a systematic issue at play. It is unhelpful and misguided to make such a simplistic inference and then recommend a blunt instrument such as the three item restriction.

A more sophisticated understanding of why many surgical procedures are billed using different multiple item numbers for the same surgery are required. Explanations for this could be a symptom of the varying clinical circumstances of individual patients; or that the MBS items established forty years ago no longer describes a complete medical service; or that the MBS is so complex that there are variable but legitimate combinations of claimed items.

A blanket application of the maximum three item restriction will not solve what appears to be a systematic discordance between the intent of an MBS item being a complete medical service and the variable claiming of highly qualified surgeons. This will only serve to withhold Medicare rebates from patients for surgical services provided and increase out of pocket costs. The proposed three item restriction is effectively coning of surgical services, where the profession absorbs the costs of providing additional services, similar to that used in the Pathology Services Table, which has seen a steady and significant degradation of investment in the Pathology sector and that the AMA strongly opposes.

The Federal Government's 2019 budget announced another significant boost to the Department's compliance ability. Inappropriate co-claiming is therefore best left to compliance to deal with. Using the MBS to dictate clinical practice is both an overreaction that will impact legitimate service delivery and moves beyond the MBS being an insurance scheme. The AMA continues to oppose it, choosing instead to support practitioners make appropriate clinical decisions, supported by improved education and MBS advice from Government.

Restriction maybe unworkable

Whilst the AMA supports the principles of the Complete Medical Service and agrees that it is not appropriate to claim additional items that are intrinsic to the performance of that procedure, it strongly opposes the proposed maximum three item restriction for the reasons discussed above and that the restriction may be impossible to implement.

Firstly, it is not made explicit in any of the surgical reports on how the restriction would be applied. That is, which items are affected and how will the item descriptors be amended to reflect the restriction. Will this restriction be implemented as an overarching rule across the majority or all the MBS T8 surgical section? If so, what data modelling has been undertaken to identify any potential unintended consequences of the proposed restriction? Are there

examples of procedures that would be in, and out, of scope for the maximum three item restriction? Further detail on this is requested to ensure that significant disinvestment and therefore patient access to surgical services does not result from this major proposed reform.

Furthermore, it is unclear from the surgical reports on the definition of a single procedure or episode of care with respect to the maximum three item restriction. This would need to be clearly defined and with consideration of the potential variability of what constitutes a single procedure amongst the different specialty groups who may use the same sets of items. Any ambiguity in the maximum three item rule will risk unintended consequences for Medicare claiming non-compliance and may not solve the issue of variable Medicare claiming. The AMA urges the Taskforce to consider whether the restriction can be practically implemented.

Finally, the AMA implores the Taskforce to consider feedback received from other craft groups regarding the maximum three item restriction. This includes strong opposition to the restriction from the AMA, the Royal Australasian College of Surgeons and the Urological Society of Australia and New Zealand in response to the MBS Review Urology Clinical Committee report in late 2018.

General Surgery Clinical Committee (GSCC) Report

The AMA notes concerns from members of CSSANZ regarding lack of colorectal input into the GSCC. The AMA urges the Taskforce to consider feedback from CSSANZ (particularly the Western Australian state Journal Club's feedback) with respect to the GSCC report recommendations.

In particular, CSSANZ noted that the maximum three item restriction would unjustifiably penalise complex intra-abdominal colorectal procedures which are often performed as emergencies. Furthermore, CSSANZ suggest that major colorectal resectional work is relatively underpaid, particularly as these procedures are provided to increasing elderly patients with significant comorbidities which require more aftercare.

CSSANZ also opposes the proposed maximum three item restriction as it believes that it seeks to reprimand the entire surgical profession and reduce medical benefits to patients rather than seeking to identify and feedback to outlying surgeons of the inappropriate behaviour. The AMA notes that the profession acknowledges that there are incidences of inappropriate co-claiming that conflict with the complete medical service. However, as CSSANZ pointed out and AMA raised earlier, the three item restriction is a heavy and blunt instrument that are more than likely to have unintended consequences such as increased patient out of pocket costs and reduced access to surgical services.

<u>Wound care</u>

The GSCC report recommends an increase in the fee attributed to some wound items to cover the costs of providing services and incentivise wound care, as appropriate, in General Practice and primary health care centres. The report also recommends removing 'aftercare' to support an appropriate fee for service.

The AMA agrees with the General Surgery Clinical Committee that wound items are undervalued, particularly as wound dressings can be costly and are not reimbursed through the MBS. The recommended fee increase and removal of 'aftercare' in the item descriptor will ensure there is appropriate reimbursement for the consumer and minimise the burden on emergency departments and hospital operating rooms.

Vascular Clinical Committee (VCC) report

The AMA notes that the VCC considered 287 MBS items related to the vascular system and these items are located under separate sections of the MBS— namely diagnostic imaging and therapeutic procedures *(see Appendix A of this submission)*. Accordingly, the VCC report recommendations impact a range of specialists and their patients— namely clinical radiologists (and sub-specialists such as neuroradiologists and neuro-interventionalists) and vascular surgeons.

According to the VCC report, of the MBS items considered by the committee, diagnostic items (ie vascular ultrasound and angiography items) account for 77 per cent of total services and 88 per cent of benefits.

Accordingly, the AMA has consulted with the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Australian and New Zealand Society of Vascular Surgery (ANZSVS) in developing its response to the VCC report recommendations.

The AMA generally supports RANZCR and ANZSVS' submissions. The AMA provides the following additional specific comments on certain recommendations as detailed below.

<u>Un-supported recommendations</u>

Recommendation 3— Item 55278: Prevent low-value over-servicing of renal duplex examinations.
The AMA opposes Recommendation 3. The Committee recommends introducing new restrictions to this item so that it can only be requested by specialists in the fields of hypertension, nephrology, vascular surgery, interventional radiology and rheumatology.

The AMA is concerned that the requirement for a specialist referral would disadvantage rural patients who already have limited access to medical specialists. Given the significant burden of cardiovascular illness amongst the Australian population, limiting access to investigations that are relatively inexpensive such as renal Doppler ultrasound, to investigate treatment refractory and atypical cases of hypertension may have some unintended consequences for the health of the community and increased costs to Government.

Renal Doppler ultrasound is a radiation and contrast material free investigation and by removing general practitioner access to renal Doppler studies, it increases the likelihood of test substitution with renal arterial CT studies, thereby increasing the community's radiation burden and contrast exposure risk. The cost of CT is also significantly higher than ultrasound and specialist referral for this test will add further burden to Medicare expenditure.

Recommendation 4 - Item 11610: Reduce the use of ankle brachial index (ABI) for screening and improve access for podiatrists and nurse practitioners.

The AMA has significant concerns about providing access to items currently only accessible by medical practitioners, to non-medically qualified providers. It would be more appropriate and more in line with the requirements for collaborative care and the key attributes of the medical home if practices were funded to engage NPs and podiatrists as part of the multidisciplinary health care team as part of a blended funding model to support comprehensive primary care.

The AMA urges the Vascular Clinical Committee to consider the issues raised in the AMA's response to the Nurse Practitioner (NP) Reference Group report (available publicly here). The AMA maintains the following position with respect to the recommendation regarding ABI:

- The AMA does not support the removal of the requirement for collaborative care in the provision of services by Nurse Practitioners (NPs).
- The AMA does not support independent access to the Medical Schedule of Services for NPs or podiatrists.
- The AMA supports the role of the General Practitioner as the key provider of primary care to patients and encourages the collaborative role of NPs both in primary care and other specialist medical practice to extend value in the health care system.
- The AMA would support practices being funded through an incentive or funding stream outside of the MBS to integrate NPs and podiatrists into their health care team and support their functions within the team.

Supported recommendations – with caveats

Recommendations 6 to 11 - Angiography
Whilst the AMA supports the intention of Recommendations 6 to 11 to modernise angiography items to reflect current clinical practice and the complexity and cost of providing image guided services, further work to revise the funding model is required. It is critical that this work involve broad stakeholder consultation and collaboration and that the proposed funding model is carefully modelled and piloted.

Most vascular disorders are able to be diagnosed without catheter angiography, but their specific morphology often requires very detailed super selective catheter angiography to determine the most appropriate therapeutic option, particularly in neurovascular disorders. Examples include (but not limited) dural arteriovenous malformations, spinal vascular malformations, brain arteriovenous malformation and arteriovenous fistulae. This work up is time consuming and requires many vessels to be catheterised with multiple "runs" in different planes. In some pathologies the completion of the diagnostic catheter workup requires several sessions (on different days) because of contrast loads, patient and operator fatigue.

Therefore, revisions to the structure of angiography items must reflect the true complexity and cost of delivering IR and INR procedures. A reduction in the remunerations for the angiographic component of IR and INR procedures would make the provision of interventional radiology services to patients unviable, particularly in the private setting.

On a separate but related concern, theatre banding fee from private health funds for Digital Subtraction Angiography (DSA) should be reviewed to ensure it reflects the true cost of running an angiography suite, ensure ongoing viability in private settings and remove the incentive to perform angiographic procedures in theatre settings.

Recommendation 16 – Items 32500-32526: Require referral from a GP for all varicose vein services

The Committee recommends that all varicose vein items require a referral from a GP for management of venous disease. The report's rationale for this is that having an initial GP review prior to referral to a treating specialist will remove patient self-referred presentations, which may be discretionary, of low clinical value or cosmetic.

The following restriction would be added to the item descriptors – 'Requiring referral for management of venous disease by a medical practitioner who is not a member of a group of practitioners of which the providing practitioner is a member'

The AMA supports this recommendation to reduce inappropriate servicing.

The Committee also recommends changes to the explanatory notes for all varicose vein items to explicitly require that all clinicians are appropriately qualified and have received the necessary training in ultrasonography for the management of venous disease. The AMA supports appropriate qualifications for providers of ultrasounds services but does not support the MBS used as a regulator of training and therefore does not support specifying training requirements in explanatory notes.

Supported recommendations

Consistent with RANZCR and ANZSVS, the AMA supports the following:

Recommendation 1

- Improve diagnostic options for duplex examination of aortoiliac and lower limb vasculature.

Recommendation 2

- Prevent low-value over-servicing of carotid duplex examinations.

Recommendation 5

- Remove low-value continuous wave (CW) Doppler investigation of venous insufficiency and obstruction.

Recommendation 9

- Replace references to "digital subtraction angiography" with "angiography and fluoroscopy"

Recommendation 11

- Support minimally invasive diagnostic alternatives to DSA.

Recommendation 12

- Add new endovascular aneurysm repair (EVAR) items to the MBS.

Recommendation 14:

- Items 34818–34833: Delete items.

Recommendation 15

- Items 33815, 33824 and 33833: Restrict co-claiming for vascular wound repair where this is considered part of the procedure.

Recommendation 17 to 20

Recommendation 25

- Item 35303: Change the anatomical descriptor to include iliac arteries for consistency across the MBS.

Recommendations 28 to 40

General comments

The Neurosurgical Society of Australasia (NSA) has raised concerns with the AMA and has written to the MBS Review Taskforce regarding the lack of active representation from interventional neuroradiologists on the MBS Review Vascular Clinical Committee and this has reflected in the recommendations of the draft report. The AMA trusts that the Taskforce will work with the NSA to address their concerns, as not doing so will risk unintended consequences of reducing patient access to interventional neuroradiology services for vascular pathologies.

Concluding remarks

The AMA's response to the various MBS Review surgical reports discussed in this submission is principled on ensuring maintaining the community's access to high quality surgical service (including rural and remote populations), that the Review modernises the MBS to reflect contemporary clinical practice and it is not simply a savings exercise for Government and that the Taskforce works with the relevant craft groups to refine the recommendations, the MBS item structure, descriptor and fees.

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APPENDIX A

The VCC recommendation categories and location within the MBS hierarchy

VCC report category	MBS Category	MBS Group	MBS Sub-group
1. Vascular ultrasound	5- Diagnostic Imaging	Group I1- Ultrasound	3- Vascular
2. Angiography	5- Diagnostic Imaging	I3- Diagnostic Radiology	13- Angiography
3. Vascular surgery	3- Therapeutic procedures	T8- Surgical Operations	3- Vascular
4. Varicose veins	3- Therapeutic procedures	T8- Surgical Operations	3- Vascular
5. Out-of-scope or referred	N/A	N/A	N/A