ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MBS REVIEW

COMMONWEALTH GOVERNMENT

NOVEMBER 2015

Summary

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training, and high standards of practice in Australia and New Zealand. RACS is the trusted and acknowledged authority on surgery, and our Fellows and staff work closely with other health organisations to promote the best health outcomes for patients and the community more broadly.

RACS purpose is centred on excellence in patient care and as a Fellowship based organisation we endeavour to give full consideration to the effects of reform measures on patient care and service provision across metropolitan, rural and remote Australia. We believe that the primary objective of any medical intervention should be to benefit the patient, and we support the vision of Medicare and the Medicare Benefits Schedule (MBS).

RACS affirms the key goals of the MBS review to deliver better patient outcomes as a result of a thorough scientific and economic assessment of the MBS items and associated rules. RACS supports that one of the review's key objectives is to eliminate the funding of low clinical value or inappropriate health services - that is, treatments, procedures and tests which are of little or no clinical benefit, through overuse or misuse, and which in some cases might actually cause harm to patients. The main goal of the review is to correctly align the MBS with contemporary practice in a way that maximises benefits to patients.

KEY POINTS

The Royal Australasian College of Surgeons affirms:

- The aims of the MBS review and is willing to assist the government through the Clinical Working groups.
- That MBS Item numbers need to reflect how medical conditions are treated today and that cost/price should be based on effectiveness and value for the money spent.
- That sustainability of the healthcare system and the judicious use of resources is an important consideration in the use of low clinical value and inappropriate procedures.
- That the review should be centered on delivering an evidence based system that adequately reflects the complexity of the surgery performed and remuneration which is also indicative of that complexity.
- The importance of the review working groups utilising the expertise of the relevant specialties and/or sub-specialties in the review of MBS items.
- That whilst there is room for improvement and updating in the MBS, the vast majority of surgical procedures conducted by surgeons in Australia are performed appropriately.

RACS has been involved in earlier reviews of MBS items and additions to the schedule, primarily through its Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) department, which provides quality and timely assessments of new and emerging surgical technologies and techniques. RACS looks forward to being able to actively contribute the expertise of our Fellowship through the Clinical Committees and Working Groups and we ask to be kept up to date on progress and included in all relevant consultations.

In practice, surgeons may sometimes struggle to use the correct item numbers because the MBS is outdated, and the descriptions provided do not equate with contemporary clinical practice. The review should be about a more evidence based system that adequately reflects the work performed and that is fair, and will lead to a more sustainable system in the future. It is therefore imperative that the review working groups utilise the expertise of the relevant specialty or sub-specialty, with further consideration given to the clinical care and decision making processes of adjacent specialties.

RACS thanks the Department of Health for the opportunity to respond to the MBS review consultation paper and we submit the following responses for your consideration.

Question Responses

Are there parts of the MBS that are out-of-date and is a review of the MBS required?

The need for reform of the MBS has become increasingly evident, and RACS is on record as supporting the Australian Government's commitment to this review. Contemporary practice shows that some items on the MBS need to be merged, others removed, and new items added to reflect changes in practice. It is essential that these processes occur concurrently to avoid any adverse impacts on patient care.

For decades, procedures have been performed which are not clearly identified on the MBS and therefore, the use of some item numbers has been open to interpretation. MBS item descriptors are very heterogeneous, ranging from broad items that do not specify the relevant procedure performed, to very specific definitions and applications. In many cases, the price attached to items does not reflect the work that is being undertaken, and in some cases, there is no available item on the MBS to describe the work being performed. There is also no qualifier around emergency surgery out of hours, where although a 'standard' procedure may be performed, the time commitment for the procedure and the peri-operative care is both greater and more complex.

Comments on the proposed MBS Review process

Review process

RACS supports the clinician led and evidence-based approach to the review the MBS. As each review and service/item differs from the next it is important that the review process takes into consideration all situations in which an item number is utilised. Some reviews will have a clear focus, impacting on a small number of items, and utilising existing good quality systematic reviews on which to base recommendations. Other reviews will involve a number of related items, a large range of sub-populations, and multiple alternative therapies; in these cases a 4-6 week turnaround on recommendations is not advisable, and probably not achievable.

A flexible approach is required for clinical reviews to ensure they are 'fit-for-purpose' and that the decisions are based on appropriate methods and evidence. As items on the MBS are merged, removed, or have their descriptors updated, it is essential that the review facilitates the addition of new items concurrently to avoid any adverse impacts on patient care and/or benefits. RACS also encourages the Taskforce to take special care when considering the impact of changes to the MBS on Indigenous Australians access to Medicare.

Previous reviews have suffered due to a lack of clear purpose and poorly defined research questions. When deciding on services and items to review, the rationale (policy, cost and clinical, including appropriate patient selection) should be made explicit to all participants. This will target the research questions to address a specific policy issue. Each review should also, depending on the required scope, make use of the most relevant range of evidence sources. This should include (but not be limited to) expert input, local data (e.g. AIHW, MBS), clinical practice guidelines, and systematic review of the evidence for safety and cost effectiveness. Horizon scanning of other fee-for-service systems maybe relevant (e.g. USA).

The review Panel has designed an approach for the review to maximise the likelihood of high-quality recommendations. RACS supports this goal in principle but again highlights the importance of clinicians operating at the frontline of healthcare, to efficiently and effectively review the available evidence and generate recommendations, together with input and feedback from consumers and other stakeholders. Having appropriate representation from relevant subspecialties is critically important, as they are best positioned with the right expertise to form conclusions on descriptions accompanying item numbers. They should also be asked to advise on relative value, compared to some standard items within their subspecialty.

RACS believes that the creation of new item numbers should form part of the review. There is clearly a need for new item numbers and the integrity of the review may be jeopardised if there are risks associated with deleting item numbers that are not immediately replaced, denying patients benefits without replacing the less-than-ideal items number with appropriate ones.

If there is no perceived problem with the safety or efficacy of a particular service, these aspects should not be a part of the review or if there are issues in terms of appropriate patient selection, reference should be made to clinical practice guidelines rather than systematic reviews as referred to in the Ontario process. The Department should provide relevant advice to the Clinical Committees and Working Groups to determine the price of items/services. Price setting should be transparent and homogeneous across the entire MBS Review, and include consideration of the cost inputs and all patient co-payment data.

Should the role of the MBS be simply that of an administrative tool, or should it be used actively to guide quality medical practice?

Evidence-based medicine is at the core of RACS purpose and values, and although the schedule was originally developed as a list of services for administrative purposes, given the range of services available and the complexity of modern healthcare it is our position is that it should be used to actively guide quality medical practice in most instances. A more active application of the schedule will require clinicians, researchers, administrators and professional organisations to work in partnership to ensure that item numbers are correctly utilised and subjected to audit and review when necessary. A provision for an audit review of procedures where 3 or more item numbers are claimed could also be considered.

What can be done to reduce unexpected variation in the MBS items claimed for similar services?

MBS Items can certainly be made more specific based on a review of the best available evidence, and they should be targeted towards patients that receive the greatest benefit from that particular service. This does not mean that items should be restricted to very specific sub-populations, but there is room to better target the current 'catch-all' items. There is a need to continue working on and getting the relative price for items as accurate as possible, while acknowledging the quality of evidence may vary from case to case. The descriptors need to be specific and reflect current practice based on evidence.

What implementation issues should be considered when amending or removing MBS items?

The primary issue to consider when amending or removing MBS items is how it will impact patient care. MBS items should not be amended without clear communication, transparent review, and the involvement of all affected groups. RACS acknowledges that bundling of items may help focus claims on better treatment outcomes. We do not support bundling where this will jeopardise patient care or result in greater out of pocket expenses.

Examples of this deficiency are in procedures such as excision of benign breast lump <50mm (31500), or insertion of venous Portacath which falls under the description of open insertion of Central venous catheter (34527) and is often more complex than the description implies. Both of these operations can be difficult in an obese patient where an assistant is required to ensure good retraction and exposure, and completion of the operation in a timely and safe manner.

We encourage review of surgical assistant fees, including procedures that generate an assistant's fee, and discourage the bundling of surgical assistant, anaesthetist and surgery items on the schedule because it will inevitably result in greater out of pocket expenses for the patient, and could introduce a perverse incentive to minimise use of assistants where an operation should not be done without an assistant.

Are there any other principles that must guide the Review?

The key principle that must guide the review is the health and wellbeing of the Australian population. The MBS needs to represent the current best practice and standards of the specialist groups. Openness, inclusiveness, and fairness should also be guiding principles of the Review, and changes need to be supported by evidence.

The schedule should encourage health providers to bill correctly, and into the future, improved auditing processes will help guide appropriate billing. The price attached to each item should be thoroughly supported by evidence and based on effectiveness, value of outcome and recognise the

complexity involved. It is also critical that the price fairly reflects the work that has been performed. The correct cataloguing of items will help ensure the sustainability of Australia's healthcare system.

RACS is not certain how the review plans to tackle the problem of multiple item numbers. However, we believe that outcomes-focus approach would be a reasonable option. As mentioned above, an audit of the use of 3 or more item numbers may be useful.

For example, surgery for lower back pain is an example of a procedure that should require specific indications to be met before being provided and then there should be an item number that covers what is considered reasonable when all the multiple item numbers are considered but using only one item number.

How can the impact of the MBS Review be measured?

Comparison of MBS expenditure, pre and post review, following implementation of outcomes and the number of complaints received may also be useful in measuring the impact of the Review. The number of disputed claims and the decrease in the variation of item numbers used by surgeons treating the same condition with the same operation, would be a good parameter.

The uptake, use and outcomes of revised MBS procedures could also be conducted by utilisation of de-identified surgical data that reflects units and States performance in an appropriate risk stratified manner. This can be used as a tool nationally to measure compliance and outcomes.

What metrics and measurement approaches should be used?

Metrics should be agreed upon in consultation with the healthcare providers and clearly explained. Data collection processes should be transparent.

How should we seek to improve this measurement and monitoring capability over time?

The adoption of guidelines to underpin and benchmark clinical activity is also needed. These guidelines would need the careful input from the relevant clinical groups. The process would also need to allow for innovation and procedure development. It is critical that the Specialty Societies are well represented in the working groups to help develop the process.

Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as a priority?

RACS notes the literature cited in the MBS review Consultation Paper with regards to knee arthroscopy, laparoscopic uterine nerve ablation and hysterectomies. It is RACS position that while there may be seldom used item numbers listed on the schedule, any changes to items must utilise the expertise of the relevant specialty or sub-specialty craft groups and consider the clinical care provided.

Rather than removing seldom utilised item numbers, an alternative might be to better utilise checklists or flowcharts based on existing clinical practice guidelines, such as those available through National Institute and Care Pathways (NICE) in the United Kingdom,[1] along with a transparent auditable process for 'think twice' procedures. This is the approach supported by the Choosing Wisely campaign, which aims to minimise inappropriate use of tests, treatments and procedures through the leadership of clinicians and involvement of consumers.[2]

There is a large cost to the sustainability of healthcare related to unnecessary and inappropriate diagnostic tests covered by Medicare. Radiology reports often are couched in language around "minor/small abnormality/probably benign/suggest another imaging test…". Imaging for spinal/back symptoms should be more refined around protocols and agreed clinical indicators. Patients should be properly clinically assessed before a decision is made about the appropriate investigation. Some investigations need to be remunerated only when ordered by a specialist surgeon.

Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

Case conferencing

Chronic diseases are responsible for nine out of every ten deaths in Australia, but wield their most enduring impact on the sustainability of the healthcare system and overall population health by reducing quality of life and functioning abilities.[3] We recommend that item numbers for 'case conferencing' via multidisciplinary teams and integrated care be considered as part of the Review, in particular to address patients with chronic disease and comorbid conditions in a more holistic manner.

Surgeon consultations

The prices for consultations by surgeons (MBS item numbers 104 and 105 - excluding neurosurgeons who are dealt with separately) do not reflect the great variation in the time and complexity of consultations. This discourages detailed discussion and communication and can result in significant out of pocket expenses for patients. Physicians can currently claim against item number 132 for thorough assessment and complex management planning for patients, but such an item is not available to surgeons.

Telehealth

There is evidence to suggest that increased telehealth facilities can deliver substantial cost savings and increased patient satisfaction, not only in rural and remote areas, but also urban settings. For example the introduction of telehealth facilities for fracture clinic patients in north western Queensland has allowed patients to access care in smaller hospitals and outlying communities in the region, rather than having to travel to larger regional centres.[4] RACS recommends appropriate remuneration for services provided by telehealth, consultations and follow up visits.

Screening

RACS supports the inclusion of screening items in the MBS, but recommends they are provided according to agreed guidelines that ensure screening does not occur unnecessarily. Where used properly, screening programs can reduce the burden of disease in Australia and increase life expectancy. For example an analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program found that people who had not been invited to participate in the screening program had a 15% higher risk of dying from bowel cancer, and were more likely to present with more advanced bowel cancers.[5]

Should cognitive (clinical diagnostic) services receive priority attention?

Yes, this should be remunerated because earlier diagnosis of impaired cognitive functioning will allow a more holistic model of care to be applied, and reduce the overall cost to the healthcare system.

Are there rules which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

RACS recommends that consideration be given to the following general rules regarding individual MBS items:

Our Fellowship has expressed concern about the following rules:

- Payment for multiple episodes of surgical care. At present this rule encourages surgeons to claim against another item so as to receive full payment for their work.
- The three month limit on specialist referrals. RACS supports a change to referrals to last one year so that patients won't have to seek additional and often clinically unnecessary consultations, simply to renew their referral. For example a patient who has received breast cancer surgery will need a mammogram and ultrasound before their annual visit. If a referral is issued at the preceding year's visit then it will be invalid by the time they need to attend the following year. Many surgeons thus 'future-date' such annual imaging requests.
- Non-specialist surgeons who are not FRACS should not be reimbursed for any reconstructive procedures, particularly after removal of skin cancers and melanomas. There may be room for

some exemptions; however the goal should be to perform surgical procedures in the simplest, safest and least expensive manner. Introducing item numbers for 'management' of particular conditions would perhaps discourage unnecessary and over complicated procedures, delivering more integrated care from start to finish for the patient.

What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

In general, simplifying the rules and associated documentation in the schedule would make it easier for clinicians to apply rules and regulations correctly. Given the current vast range and complexity of services on the MBS, and the fact that many items are often required to provide a single service, a summary would be useful, especially for costly conditions or those which require careful patient selection. Clarify the regulations and remove ambiguity from the schedule

As mentioned above, NICE Pathways in the United Kingdom utilises flowcharts to help guide clinicians in their decision making about the most appropriate course of care for individual patients.

These summaries can include:

- The steps involved in patient selection
- Relevant tests (including type and frequency)
- Therapy choices. These should include issues such as watchful waiting and decisions regarding palliative care.

The flowcharts could be based on existing clinical practice guidelines, with their development beginning as part of the current MBS review and continuing into the future.

Are there existing rules which are causing unintended consequences or are outmoded and should be reviewed?

See above.

Are there alternative solutions to deliver the original intent?

To decrease over investigation, over treatment and overuse of item numbers, reviewers will need to recognise the medico-legal environment as a key driver.

In amending any existing rule/s, are there potential adverse impacts on consumers, providers, or government?

Any amendments to existing rules should utilise the expertise of the relevant specialty or sub-specialty, consider the clinical care and decision making processes of adjacent specialties, and have better patient outcomes as the key goal.

Are there any new rules which should be introduced?

Some MRI scans are not covered by the MBS and RACS recommends a review of appropriate scans to include necessary scans, where it should only be possible for relevant specialists to order some tests. Those ordering tests need to be held to greater account and it may be useful to introduce an annual limit on certain tests with authority required for more. Special patient groups could be defined and have automatic allowances made. Please note earlier comment about suggested/advised further imaging by radiologists.

Are there medical services which should not be funded for reasons other than concerns about safety and/or clinical efficacy? How can these be defined unambiguously?

These can be identified through review of existing item descriptors and notes, and the review Clinical Committees and Working Groups comprising relevant key experts.

What kind of information do consumers need to better participate in decisions about their health care?

RACS recommends that the Taskforce consider how information about MBS items and services can be communicated to patients more appropriately, to give them greater insight into the impact of their decisions. This information should also explain the fees and costs (including co-payment) associated with the item or service. Patients and consumers should have access to unbiased information provided in a clear manner. This is largely determined by the patient/doctor interaction, rather than through the assignment of MBS numbers.

RACS supports the public release of outcomes-based data on surgical performance at a team, institutional or national level. It is appropriate that the public have access to reports on surgical performance that are valid, reliable and that establish trust so that providers and their patients can be confident in the medical care being provided.

In the past, RACS has published consumer summaries of systematic reviews undertaken by its ASERNIP-S Department.[6] Due to lack of resources, this service is no longer available. Summarised information from MBS reviews and MSAC assessments would help consumers understand proposed treatments and inform them about what to expect during their patient journey.

Should the MBS be used to encourage more systematic collection of data?

The purpose for more systematic data collection should be clear, along with its intended use. RACS recommends that the Taskforce consider how data from surgical audits and eHealth could be made compatible with the MBS. Linking these datasets would provide a powerful tool for future review and research.

RACS has a range of detailed datasets include the Australian and New Zealand Audit of Surgical Mortality and the Morbidity Audit and Logbook Tool. There are also existing national audits - vascular, breast cancer, colorectal cancer and joint prosthesis audits which could be drawn upon.

Are there MBS items which could have health outcomes data readily linked to the provision of health care?

MBS services could be linked to national health priorities, for example specific cancers, diabetes, cardiovascular disease, and mental health. Selecting items and outcome measures would require careful consideration and input from a multi-disciplinary team.

Should MBS items support participation in the creation or development of other data sources? E.g. myHealth Record, clinical trials, funding linked to evidence production.

RACS supports the use of MBS items to create/develop other data sources. For certain novel services which offer a unique alternative to patients with conditions related to high morbidity or mortality, Medicare support for trials would allow quicker access to therapies and associated evidence development. Support for these services should be considered on a case-by-case basis.

[1] Colorectal cancer - NICE Pathways. Accessed 26 October 2015. Available from: http://pathways.nice.org.uk/pathways/colorectal-cancer

[2] Choosing Wisely Australia welcomes new Colleges, societies and associations. Accessed 27 October 2015. Available from: http://www.choosingwisely.org.au/.
[3] Willcox S. Chronic diseases in Australia: the case for changing course. Mitchell Institute; 2014. Accessed 26 October 2015. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/Chronic-diseases-in-Australia-the-case-for-changing-course-sharon-willcox.pdf
[4] The Royal Australasian College of Surgeons. Media release: Telehealth a proven recipe for success for isolated communities. 2015. From: www.surgeons.org. Accessed 2 November 2015.
[5] Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program. 2015. Accessed 26 October 2015. Available from: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549722
[6] The Royal Australasian College of Surgeons. Patient Information: Dermal fillers. 2009. From: http://www.surgeons.org/media/310925/CON_2009-03-31_Dermal_fillers_consum_FINAL.pdf. Accessed 2 November 2015.