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SUBMISSION

AMA to MRAC Post implementation review of changes to colonoscopy MBS items

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1. MBS items for colonoscopy services are amended to require the reporting of results to platforms that enable ready access to results by all healthcare providers.

The AMA supports the aspiration of this recommendation but cannot support it. The AMA is concerned with the use of an MBS item to drive uploading of reports to My Health Record (MHR). The reality is that if an upload does not occur and the requirements of the item are not met, the patient will be denied the MBS rebate and have to pay the full cost of the service.

While the AMA is supportive of MHR and uploading to it, there are better mechanisms outside of MBS item amendments to drive this behaviour. The Practice Incentives Program eHealth Incentive for general practice has encouraged general practices to integrate MHR and encourage uploading by GPs. Failure to upload means practices will miss the incentive payment, but the patient is not denied the rebate.

The AMA is supportive of the ultimate goal of this recommendation, and if MRAC were to support it in the final report the AMA suggests that the three year horizon is included. Throughout this period, there will need to be significant improvements to clinical software and improvements to MHR to ensure that it is practical for clinicians. The AMA does not support it in the current environment. Appropriate support and guidance will need to be provided to clinicians to facilitate this goal.

It is important to note that the same day upload requirement may not be practical and does not necessarily add benefit. We suggest that the wording is changed to “within 48 hours” to allow flexibility when procedures are performed later in the day or on weekends.

2. The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy amends the recertification approval process to require compliance with Quality Statement 9 of the Colonoscopy CCS.

The AMA supports the work of the Conjoint Committee for Recognition of Training (CCRT) in Gastrointestinal Endoscopy and the statements and indicators in the Colonoscopy Clinical Care Standard. The AMA notes that the purpose of the CCRT is to drive quality and safety improvement, not compliance with standards. The AMA does not object to this

recommendation, however we strongly recommend that practical discussions are had with the CCRT to determine how this would work and whether it aligns with their current structure and purpose.

3. Improved education of both providers (including GPs, endoscopists and private hospitals) and patients is needed to promote high-quality colonoscopy.

The AMA is supportive of improved education materials and direct communications to GPs and proceduralists. The AMA suggests that this work should be clinician led and must involve the Gastroenterological Society of Australia (GESA).

4. The Department and/or other agencies, including AIHW, to promote or develop clinical decision support tools that inform the absolute risk of colon cancer for different age groups for both patients and clinicians.

The AMA supports clinical decision support tools being integrated into clinical software to aid clinical decision making. The AMA is unclear on the role the AIHW would play in developing clinical support tools as they collect and report on data, they have no role in clinical guidelines or direct interaction with clinicians. This work should be led by clinicians, with department/agency support for distribution. The Australian Digital Health Agency could lead work integrating this into clinical software. The GESA must be involved in the development of clinical support tools.

5. Improve equity of access for regional and remote populations by supporting ongoing development of the GP-endoscopist workforce through rural generalist training and expanding outreach models.

The AMA is supportive of this proposal, noting the challenges of rural specialist medical training. The AMA is aware of GESA's Regional, Remote and Indigenous Outreach program in Alice Springs which provides a positive example of efforts to address this issue.

The AMA is not supportive of the expansion of the role of nurse endoscopists while there is a national scope of practice review underway.

Additional consultation: Separate the positive FOBT indication from MBS item 32222 and limit direct access to colonoscopy to only FOBT-positive patients or those with a positive history of blood in the stool.

The AMA does not support requiring an additional consultation with an endoscopist before a colonoscopy. This has the potential to undermine the goal of the change and increase waiting lists and costs to the MBS by adding additional consultations and as a result reducing colonoscopies performed.

We agree that the lack of access is an issue and would welcome further discussions about it. The AMA Council of General Practice meets four times a year and would welcome a discussion with MRAC about referrals, education, and access. Please contact nelmitt@ama.com.au if you would like to arrange to speak to them on this issue.