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MBS Review Pain Management Clinical Committee Report

AMA submission to the MBS Review Taskforce

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Introduction

The Australian Medical Association (AMA) welcomes the opportunity to provide a response to the draft MBS Review Pain Management Clinical Committee (PMCC) Report. The AMA has always stated its support for a review of the MBS, provided it is clinician-led with a strong focus on supporting quality patient care.

The AMA generally refers to the relevant colleges, associations and societies (CAS) for their clinical expertise and advice on the report findings and recommendations at this level of detail. The AMA therefore notes with great interest, the important feedback, from the Royal Australian and New Zealand College of Radiologists (RANZCR), the Australian Society of Anaesthetists (ASA), the Royal Australian College of General Practitioners (RACGP) and the Australian Private Hospitals Association (APHA).

Given the multidisciplinary nature of pain, the PMCC is urged to undertake continuing consultation with a wide range of medical/general practitioners, consultant physicians and specialists including (but not limited to) diagnostic radiologists, interventional radiologists, palliative medicine specialists, neurosurgeons, orthopaedic surgeons, rheumatologists, paediatricians, and oncologists; and allied health craft groups who provide care in this highly complex and evolving discipline.

The AMA notes the 32 recommendations that the PMCC report has grouped into the following categories:

1. Nerve blocks and spinal injections
2. Implanted devices
3. Surgical co-claiming
4. Better access to multidisciplinary care for chronic pain management
5. Access to initial co-morbidity consultation items
6. Access to Botox for pelvic tension myalgia

Craft groups such as the Australia and New Zealand Society of Palliative Medicine (ANZSPM), Clinical Oncology Society of Australia (COSA), Medical Oncology Group of Australia (MOGA) and Royal Australasian College of Surgeons (RACS) should be consulted, if not already.

Accordingly, the AMA's response is focused on the PMCC recommendations related to better access to multidisciplinary care for chronic pain management and access to initial co-morbidity consultation items.

Better access to multidisciplinary care for chronic pain management

Pain as a chronic and complex condition

While at the moment the definitions and affirmation of chronic pain as a chronic disease may vary, the National Strategic Action Plan for Pain Management launched by the Australian Government in 2019 envisages that pain is included in chronic conditions frameworks, being brought forward by governments or health and medical groups.[1] In addition, the Coordination of Health Care 2016 report, recently released by AIHW defines long term health condition as a condition that is expected to last or has lasted 6 months or more- consistent with the MBS, amongst which moderate or severe pain is listed within their definition.[2]

The AMA recognises the need for more efficient arrangements to support the provision of well-coordinated multidisciplinary care to patients with chronic and complex disease. If access to coordinated multidisciplinary care is improved then patients will benefit, the number of avoidable hospital admissions can be reduced, and long-term savings to the health system will be generated.

The AMA[3] supports a comprehensive approach to the management of chronic and complex disease based on arrangements that:

- Provide GP-coordinated access for patients to services based on clinical need;
- Provide a patient's usual GP with the support they need to improve the care they can provide/organise for patients with chronic and complex disease;
- Support GPs to facilitate access for their patients to other members of a multidisciplinary primary care team;
- Continue to ensure that funding follows the patient;
- Lead to better collaboration with existing service providers; and
- Simplify and enhance the existing MBS chronic disease arrangements.

[1] https://www.painaustralia.org.au/static/uploads/files/national-action-plan-11-06-2019-wfflaefbxbdy.pdf
[2] AIHW (2019) Coordination of Health Care: Experiences of information sharing between providers for patients aged 45 and over 2016
[3] AMA Chronic Disease Plan (Revised 2012)

Nerve blocks and spinal injections

AMA notes that the PMCC report recommended revision of descriptors for spinal injections for management of chronic pain to bring greater clarity about clinical practice and also to differentiate them from radiological diagnostic procedures, which have their own item numbers.

AMA would however like to point out that radiologists still have a role to play in pain management procedures. CT guided pain management procedures carried out by appropriately trained radiologists, particularly cervical root sleeve blocks, are highly effective and have a much lower adverse event rate compared to fluoroscopy guided procedures carried out by pain management specialists. There are many publications supporting this.[4,5,6]

When considering MBS items 39013, 39118 and 39323, the committee considered restricting use of CT guidance due to safety and radiation exposure but determined that there was not strong enough evidence against CT and recommended that items that include CT guidance be reviewed again in 2 years. AMA supports the PMCC conclusion. CT radiation dose for these procedures is extremely small and radiation exposure should not be part of the argument against CT guided procedures.

Need for broader coordination with other MBS review committees

The AMA believes there should be broader coordination between the review undertaken by the PMCC and other MBS reviews conducted. The PMCC report and proposed changes cannot be viewed separately from work being done by other MBS review committees. The referrals to Thoracic Surgery Committee, Vascular Clinical Committee and others are welcomed, however there needs to be close coordination between the work of the MBS Review Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC), General Practice and Primary Care Clinical Committee (GPPCCC), Allied Health Reference Group (AHRG) and the PMCC.

Broader coordination between these is needed to ensure the purpose, proposed changes and implemented recommendations from the various but related Committees do not conflict and contradict each other. This would not only cause confusion for doctors and patients, and increases risk of unintended consequences.

Specifically, SCPCCC has considered case conferencing in their report, noting that currently MBS has 55 case conference items. In order to reduce this number, SCPCCC is recommending that all consultant physicians are allowed access to specific MBS items under three categories of case conferencing: discharge planning, community case conference and treatment planning (includes 6 new items). AMA notes that as defined currently, these three items may be broad enough to

[4] A Gangi, J L Dietemann, R Mortazavi, D Pfleger, C Kauff, C Roy (1998). CT-guided interventional procedures for pain management in the lumbosacral spine. https://pubs.rsna.org/doi/10.1148/radiographics.18.3.9599387
[5] Ezio Fanucci et al (2001). CT-guided injection of botulinic toxin for percutaneous therapy of piriformis muscle syndrome with preliminary MRI results about denervative process https://link.springer.com/article/10.1007/s003300100872
[6] R. Silbergleit et al (2001). Imaging-guided Injection Techniques with Fluoroscopy and CT for Spinal Pain Management. https://pubs.rsna.org/doi/full/10.1148/radiographics.21.4.g01jl15927

incorporate pain management planning. Under recommendation 26(d), the PMCC recommends introduction of Multidisciplinary Chronic Pain Management Plan review item or access to case conferencing available to each member of treating team. This PMCC recommendation should be reconsidered within the context of the issues explored and the craft group feedback from the SCPCCC report. Community case conference items for example could include multidisciplinary chronic pain management plan, without the need for creating a new MBS item.

Additionally, the SCPCCC recommended the removal of the high complexity consultant physician attendance items 132 and 133 and that items should instead be claimed using the proposed standard time-tiered attendance items.[7] Again, Recommendation 31 of the PMCC report - access to items 132 and 133 should be reconsidered within the context of the developments of the SCPCCC report.

It should be noted that in its submission to the SCPCCC report, the AMA strongly opposes the proposed deletion of complex care plan items and their replacement by standard time-tiered attendance items (Recommendation 5, SCPCCC report). The AMA encourages the PMCC to consider AMA and other craft groups' feedback on the SCPCCC report.

PMCC recommends introduction of Chronic Pain Management Plan item under Recommendation 26(a). In their report, GPPCCC recommends that the list of Chronic Disease Management items in which GPs are involved include a strengthened definition of chronic condition, being a condition that "requires a structured and holistic approach", with detailed guidance added to the explanatory note on what does and does not constitute a chronic condition.[8] AMA suggests that chronic pain could be considered for inclusion in coordination with other ongoing reviews including GPPCCC, rather than introducing a separate item.

The AMA urges the PMCC to reconsider Recommendation 27 – Access to appropriately trained allied health services, within the context of the GPPCCC, AHRG and SCPCCC report considerations. The AMA notes that Recommendation 27(c) is not dissimilar to Recommendation 19 of the MBS Review Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) report which proposes consultant specialists to have access to a small number of 'Allied Health Professional (AHP) bridging referrals' that are eligible for a rebate, but only after a full review of the evidence and the associated costs and benefits of any suggested pathway.

The AMA notes that currently consultant specialists can refer to AHPs but without access to a Medicare rebate, but if this recommendation is adopted a patient rebate will be made available via a consultant specialist referral. Under the current MBS structure, for patients to access a rebate, they must be assessed by their GP for eligibility and development of a GP Management Plan (item 721). If granted, the patient can access up to five AHP visits with a rebate.

[7] Medicare data 2016-17

[8] https://www.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/%24File/General-Practice-and-Primary-Care-Clinical-Committee-Phase-2-Report.pdf

The AMA acknowledges that there is space for specialist's referral to allied health in the AMA's recently lodged submission into the SCPCCC, but requests evidence of how this policy change would not detrimentally impact upon the GP as a central component of a member's health.

Again, consistency of recommendations between these committees and coordinated consideration of the feedback from relevant stakeholders is required to prevent contradictory goals and outcomes, and most importantly, limit unintended consequences for patients and specialty groups. Afterall, the purpose of the MBS review exercise was to reduce duplication, confusion and mis-claiming.

GP at the centre of multidisciplinary care

The AMA does not support the introduction of a multidisciplinary chronic pain management plan item number or the construction of single-condition item numbers (PMCC Recommendation 26). The AMA notes and supports the RACGP's suggestion that existing chronic disease management item numbers can be used for chronic pain.

The MBS explanatory note AN.0.47 states that *"items 721, 723, 729, 731 and 732 provide rebates to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal."* The AMA suggests that Recommendation 26 is redundant, and rather, education and promotion amongst the profession for the use of the existing Chronic disease times for pain management would be more appropriate.

Furthermore, as patients with chronic pain often present with multiple and not single conditions, existing GP Management Plan and GP Mental Health Treatment Plan items should be optimised to ensure best practice pain management. The PMCC is strongly urged to work with other MBS Review committees such as the General Practice and Primary Care Clinical Committee (GPPCCC) and Allied Health Reference Group (AHRG) to leverage and work in alignment with their recommendations and stakeholder feedback. The PMCC are requested to refer to AMA's feedback on the GPPCCC and AHRG reports.

It is AMA's view that GPs should continue to play the key role in any multidisciplinary teams. This is reinforced by the recommendations of the SCPCCC, who warns against exclusion of GPs from complex plans: "Plans should be additive and synergistic, building on the initial plan that was created, rather than being separately created and existing as a stand-alone entity. Specifically, it was noted that the consultant specialist should build upon a consumer's General Practice Management Plan (where one is in place) and relate directly to the patient's goals."[9]

It should be noted that Recommendation 26(b) of the PMCC report appears to erroneously refer to items 132 and 133, which are specialist consultant attendance items. The AMA provides the

[9] https://www.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/$File/SCPCCC%20Report.pdf

above commentary on the assumption that Recommendation 26(b) is in reference to Chronic disease items such as 721, 723, 729, 731 and 732.

Pain management telehealth items

The PMCC recommend the creation of pain management specific telehealth items for multidisciplinary (medical, nursing and/or allied health professionals) assessment and review for pain management patients. Recommendation for use of telehealth in complex pain management is welcomed, but as always, should extend beyond just pain management. AMA members, physicians and other specialists who treat patients in rural and remote communities find telehealth beneficial for their practices and for rural patients.

The PMCC should be aware that the SCPCCC report proposed phasing out of telehealth MBS items for consultant physicians over the coming year and reinvesting the savings into promotion activities. SCPCCC proposes introducing time-tiered telehealth consultations after a period of intense promotion of telehealth to consumers. As increased involvement of physicians in complex pain management is expected under the proposed changes, there should be some coherence between the work of the two committees.

It should be noted that the AMA strongly opposed the SCPCCC's proposed changes to specialist consultant telehealth attendance items. Furthermore, the AMA supports the PMCC recommendation for the use of telehealth items by multidisciplinary team members providing complex pain management care.

Accreditation requirements for GPs and other professionals

GPs already manage most chronic pain patients. Most visits to health professionals by people experiencing chronic pain are made to their GP[10]. Multidisciplinary approach to pain management with involvement of GPs is welcomed by the AMA, as GPs do most referrals to allied health professionals and currently they are the only ones who can make referrals for MBS rebated items.

The line of comparison is drawn in the PMCC report between mental health care plans that GPs develop and pain management plans. However, the mental health planning training that GPs are expected to attend to be able to claim MBS items under mental health plan category are: completion of an accredited mental health skills training course (primary or modular pathway; 6 or 7 hours in duration; online or face to face) items 2715, 2717; or completion of an accredited FPS ST (20 hours minimum; 12 hour minimum face to face/live interactive training; 8 hour minimum interactive structured learning activity) items 2721, 2723, 2725, 2727. Conversely, the model proposed by the PMCC requires GPs to attend a 6-month training.

Under Recommendation 26(a), the PMCC recommends that GPs would be able to access specific MBS pain management items only if they are accredited by a 6-month diploma in pain medicine when it becomes available. The AMA strongly opposes the additional requirements for

[10] https://www.nps.org.au/news/chronic-pain#r42

accreditation of GPs—who currently provide effective chronic pain management through a strong, continuous therapeutic doctor-patient relationship and integrated multidisciplinary care. Given the GP's regular contact with the patient and knowledge of the patient's medical history, they are best placed to manage and review patients with chronic pain.

Furthermore, in order to access case conferencing or multidisciplinary chronic pain management plan review item, would these GPs be expected to stop treating their patients until they get this new accreditation? This would create a situation where there are no GPs qualified to provide pain management in the entire country for at least six months. Beyond that, few GPs are likely to undertake the sixth-month training leaving a major vacuum in pain management services at the first point of care for Australians.

Additionally, the expectation is that they would have to fund the accreditation themselves. The financial viability of such arrangements for GPs needs to be further explored. According to the MABEL (Medicine in Australia: Balancing Employment and Life) longitudinal survey of more than 8000 GPs and other specialists, GP earnings have been falling since 2015[11].

Recommendation 26(a) also proposes that access to the new multidisciplinary Chronic Pain Management Plan item be made available to specialist pain medicine physicians. The AMA is unclear about who these pain medicine specialist physicians are— noting the Faculty of Pain Medicine's (FPM, a faculty of ANZCA) position statement in 'Procedures for Pain Medicine'. FPM's statement of intent number 2 implies that non-FPM specialists in Australia and New Zealand would require additional training and/or endorsement from FPM to continue to perform procedures that are already within their scope of practice. The AMA supports RANZCR's views that specific training in pain procedures is warranted, due to the complexity, technical difficulty of procedures. However, as stated in RANZCR's response to FPM's position statement, "it is unrealistic to expect that all craft groups, who are already recognised by their respective Colleges, should be credentialed by the FPM or ANZCA to perform procedures for pain management".

Patient access to specialists for appropriate management of chronic pain is already a significant issue. Adding accreditation requirements will only serve to further restrict patients' access to pain management services, in particular, this would have significant detrimental effects on populations such as patients living in rural and remote areas and vulnerable communities.

The AMA notes that Recommendation 28 refers to participants to be accredited in chronic pain management as determined by the relevant colleges or professional bodies, to access the proposed multidisciplinary Chronic Pain Management review and case conferencing items. The AMA requests clarification of the difference, if any, between the qualifications required to access the proposed new multidisciplinary Chronic Pain Management item (Recommendation 26a) compared to those in Recommendation 28.

[11] https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0008/2956463/MABEL-User-Manual-Wave-10_Jan2019.pdf

Shared medical records

AMA notes that My Health Record availability is not acknowledged by the PMCC, even though the Pain Management Report recommends sharing of medical records by all specialists involved in treatment of patients. The basis behind establishment of My Health Record was so that all treating practitioners could have access to patient's file and be able to work together and provide consistent treatment. In that sense, My Health Record would be an ideal tool for all practitioners involved in treatment and pain management of patients. Creating a new system for sharing of records by practitioners involved in pain management will simply duplicate the efforts of the My Health Record system, and this cannot be supported by the AMA.

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