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Professor Bruce Robinson
Chair
Medical Benefits Schedule Review Taskforce
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Dear Professor Robinson

RE: Medicare Benefits Schedule (MBS) Review – Pathology Clinical Committee and Diagnostic Medicine Clinical Committee (DMCC) reports

I am writing to provide feedback on the MBS Review Diagnostic Medicine Clinical Committee (DMCC) report; as well as the seven sub-specialty reports from the Pathology Clinical Committee (PCC), which include Haematology, Chemistry, Microbiology, Anatomical/ Cytology, Immunology and Genetics.

In the first instance, 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. Accordingly, I write to make you aware of the broader strategic and policy aspects that have been commonly raised by AMA members or the CAS groups in relation to these clinical committee reports.

Whilst the AMA provides some response to specific item changes below, we are not in a position to comprehensively cover off on all the clinical recommendations. Therefore, the AMA urges the MBS Review Taskforce and clinical committees to consider the specific clinical feedback the CAS groups provide on the review recommendations, as they are best placed to respond in detail and provide clinical evidence and best practice options.

AMA's response to the above reports are detailed at Attachment A – DMCC and Attachment B – Pathology sub specialty reports.

Yours sincerely

Dr Tony Bartone
President

Attachment A: Report from the Diagnostic Medicine Clinical Committee

The AMA notes that the DMCC was established to advise on mechanisms to support better requesting of diagnostic services (including diagnostic imaging and pathology services). The Taskforce asked the Committee to review a set of high volume, high benefit MBS items that are predominantly requested by general practitioners (GPs).

The DMCC reviewed a total of 68 MBS items, including 17 pathology and 51 diagnostic imaging items, with recommendations proposed in the following priority groups:

Pathology items

- Vitamin B12 (66838 and 66839)
- Iron study items (66593 and 66596)
- Folate item (66840)
- Urine testing items (69300, 69333 and 73085)
- Vitamin D items (5 items)
- Prostate-specific antigen (PSA) items (4 items)

Diagnostic imaging items

- Ankle/ hind foot ultrasound (4 items)
- Shoulder/ upper arm ultrasound (4 items)
- Lower back imaging (18 items)
- Head imaging (25 items)

Inappropriate Requesting Restrictions

The AMA notes that the DMCC based its recommendations on rapid evidence review, clinical expertise and MBS item utilization data. The AMA is aware of the concerns of Australian Pathology (AP) and the Royal College of Pathologists of Australasia (RCPA) regarding the basis of the recommendations in the DMCC report. I understand their concerns relate to the perceived poor quality of the evidence, often with recommendations that are inconsistent with accepted Guidelines, recommendations that are based on incomplete Medicare data due to coning, and reliance on committee opinion. It is deeply concerning that the College and the national peak body for private pathology—Australian Pathology, rejects the majority of the DMCC report recommendations.

Clinical Decision Support

The DMCC recommended implementing an electronic Clinical Decision Support (CDS) system Australia-wide, with requirements for mandatory CDS attached to rebates for selected diagnostic imaging items.

The AMA considers Clinical Decision Support (CDS) systems to be useful tools to educate and inform clinicians of current best practice, at the point of care, for requesting of diagnostic tests and availability of MBS rebates. However, the AMA believes that the DMCC recommendation for a mandatory CDS system would, as an AMA representative conveyed "tie doctors' hands behind their back", effectively hindering their ability to tailor care for patients. The AMA urges the MBS Taskforce to implement a non-mandatory CDS system and/or allow clinicians to continue to exercise their clinical judgement in relation to the particular circumstances of the patient they are treating.

The AMA notes that implementation of the CDS into practices would be at a cost to providers and that financial and other relevant support should be provided to assist with this.

Furthermore, if a CDS system is implemented, a key issue will be to ensure the system is integrated into clinical software, and not be a stand-alone system, so that pathologists can communicate results quickly, effectively, and equitably to requesting and treating doctors.

The CDS software should also remain in the control of Government and the profession, not the software vendors. This could be controlled via a CDS licensing system whereby the Government and the profession develops specifications and standards to maximise effective interoperability and utility and maintains ongoing intellectual property rights and control of the system. The AMA would be happy to be involved along with the relevant CAS groups and Government to progress the development of a non-mandatory or acceptable CDS system, particularly building on the recent national roll out of My Health Record.

I have been advised that CDS prototypes exists and feedback from members reveal there are several good systems worldwide for radiology including the one developed at Royal Perth Hospital in Western Australia. I am also aware that the RCPA has undertaken extensive work (funded by the Department of Health) in developing CDS prototypes for pathology. It would therefore be logical for the Taskforce to leverage this work, if the initial trial of CDS for radiology items proves acceptable to the medical profession and is effective in ensuring clinically appropriate requesting of diagnostic tests.

I should highlight that within the profession there is, as you would expect, a range of views on these issues. However, I found a largely unanimous view that inappropriate testing is something that should be contemplated, and to that end would convey the views that making the costs of tests visible—preferably at the requesting stage, is something that should be considered.

Attachment B: Report from the Pathology Clinical Committee

Implementation

The pathology sector is high volume and low margin, with significant cross subsidisation across pathology services. Any changes or dis-investment in one area of pathology could destabilise other parts of the system. The AMA urges the Taskforce and Government to work with the Pathology sector to undertake staged implementation of changes that are acceptable to the sector as well as continued agreement on a cost neutral impact.

To that end, the AMA suggests that the ideal mechanism to ensure implementation issues are robustly discussed and addressed; planned and monitored, is through the establishment of an implementation group of representatives from public and private pathology services and Government. Furthermore, it would be vital for the implementation group to undertake financial and economic modelling of the recommendations, at the practice level (to remove effects of coning), before implementation to identify any potential unintended consequences. The data modelling will need to be timely so that if implementation issues are identified, they can be acted upon quickly. Considering the high volume, low margin and complicated cross subsidies inherent in the pathology system, there is a real risk that the MBS Review could inadvertently remove a considerable quantum of funds from the sector.

The requirement for financial and economic modelling is demonstrated by the dichotomy of effects of the recommendations in the Anatomical (Tissue) Pathology sub-specialty report to remove all within-level coning/tiering, to have a single item for each histology complexity. On the one hand the AMA supports increased funding to this traditionally underfunded area of pathology, however, we strongly advocate for data modelling to ensure the recommendation is implemented in such a way that does not have significant negative impacts on other parts of the PST.

An AMA member's comment in support of this recommendation states that:

> *"This is a very significant issue in the 'hands-on', labour intensive specialty of Anatomical Pathology/Cytology. Significant amounts of unfunded testing is currently absorbed into the running costs of the practice. Whilst multi-disciplinary labs can offset these shortfalls against gains in other areas/disciplines, in single discipline labs such as ours, the time, labour and consumables all go unfunded. This has been an ever-increasing financial burden on the delivery of a high-quality service such as we deliver to our clinicians and their patients."*

AMA position on pathology services

The AMA requests the Taskforce to consider AMA's position statement on pathology services, in its deliberation of the PCC recommendations, to ensure unintended consequences do not result. The relevant key positions are provided below.

Government policies and funding arrangements for pathology services should:

- place primary importance on safety, quality, access and affordability;
- facilitate patient care and convenience, including in regional and rural areas;
- support sustainability of the pathology sector including the sector's ability to support ongoing training, research and development;
- recognise the savings to the healthcare system and the general economy from early diagnosis and intervention and monitoring of chronic disease which are facilitated

through pathology services; and

- appropriately reimburse the patient for the full cost of providing pathology services.

The AMA supports:

- fee-for-service payments which encourage competition within the sector while maintaining quality services;
- annual indexation of Medicare Benefits Schedule (MBS) fees for pathology services at rates that reflect increases in the CPI and LPI;
- abolishing current coning restrictions – each service provided should attract an appropriate MBS rebate;
- an appropriate geographic spread of pathology services sufficient to provide affordable and timely access to results for all patients in Australia.

Furthermore, we would agree with AP, particularly in regard to the fact that:

- Any changes or revisions made to current Pathology MBS items will not result in an overall reduction in the funding of Pathology services.
- Any new item which requires approval via MSAC will have new, additional funding. New funding is not indexation or volume growth – we have seen the sector suffer a result of this tendency in the past;
- A separate streamlined and timely MSAC process will be developed for Pathology items to help reduce the current delay in evaluating and listing new items on the PST.
- Changes or revisions to the PST and to the administration of the Medicare schedule should simplify the schedule with deletion of redundant and ambiguous item descriptors and streamline administrative processes;
- There be a mechanism involving the sector to try and deal with the issues between the DMCC report and the other committees.

<u>Obstetric and Gynaecology related recommendations</u>

The AMA opposes the bundling of antenatal investigations as proposed in recommendation 15 of the PCC Microbiology report, as there is no clear reasoning for this change. Particularly confusing is the frequency restriction on the new bundled item which, on the one hand, will be subject to 'Rule 25 once per year per pregnancy', but then the report goes on to state that additional serology and urinalysis tests can be claimed if clinically indicated. The bundled item with subsequent exceptions on frequency of individual test increases the complexity of the PST and claiming, and this is likely to contribute to increased inadvertent Medicare non-compliance.

Furthermore, the detailed and prescriptive item descriptor of the proposed bundled item, limits the medical practitioner's ability to customise the pathology testing for the patient's particular clinical circumstance. For example, women who have been in Zika prevalent areas should be able to access Zika testing. Similarly, women who garden or who have cats should be able to access toxoplasma serology and women whose pregnancies are complicated by hydrops need Coxsackie, echo and parvo virus serology.

PCC - Anatomical /Cytology report

The AMA supports ‘Recommendation 7 - Second Opinion items’ as there has been great confusion in the use of these items, with significant under-utilisation of the codes through fear of potential misuse and clarification of appropriate use is required.

Regarding ‘Recommendation 8: Pathologist-determinable items’— this is an emerging issue that needs resolution. Molecular testing and 'Companion diagnostic testing' are often required by clinicians for patient prognosis and determination of access to appropriate post-operative treatment or clinical trials, however, a requirement for these tests are often not known until after a pathologist has made a diagnosis. Frustratingly, pathologists are often aware of the need for this supplementary testing at the time of completing their report, but testing is delayed until a secondary clinician sees the patient and rings to add the additional tests; the system would be improved by allowing pathologists to initiate tests they know will be subsequently required.