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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 – Neurosurgery, Neurology, Colonoscopy and Orthopaedics

I am writing to provide feedback on the MBS Review reports received in September and October last year, from the following clinical committees: neurosurgery and neurology, colonoscopy and orthopaedics, as part of the MBS Review Taskforce's targeted consultation.

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.

Neurosurgery and Neurology
The AMA notes and commends the MBS Review Taskforce on the broad representation of the Neurosurgery and Neurology clinical committee; which included representatives from the Neurosurgical Society of Australasia (NSA), the Australian and New Zealand Association of Neurologists (ANZAN), the Royal Australian College of General Practitioners (RACGP) and the Australian Pain Society.

The only feedback the AMA wishes to make on the Neurosurgery and Neurology Clinical Committee reports, relate to the recommendation to develop a standardized national referral form for a number of routine test requests (ie recommendations 1,3 and for electroencephalography—EEG, nerve conduction studies—NCS, electromyography—EMG and evoked response testing). The AMA notes that this recommendation is to discourage low-value use and assist clinicians in determining when to refer directly to a neurologist, rather than requesting further testing that is not supported by the evidence.

Whilst the AMA agrees with the principles of encouraging best practice for referrals, we request that the national referral forms not be made mandatory, as this would produce unnecessary red

tape when the goal is to simply inform doctors of what constitutes a low-value referral. It would be best if guidance was provided to GPs on what information should be included in a referral form rather than mandating a government designed form. Certainly, an example of a compliant form could be included, as it is about the information conveyed by the form, not the design of the form itself. The various GP practices and software providers could then design a form suitable to their needs.

Doctors have a limited amount of time with their patients, and the more time required to complete forms that are not integrated with their practice systems, means less time focusing on their core activity of providing high-quality health care to their patients.

Referral forms should be consistent with the AMA's 10 Minimum Standards for Medical Forms, which identifies the following key standards for forms: be available and accessible, value GP time, not onerous and respect privacy and is easy to administer.

The clinical committee report suggests that the referral forms should be developed by the Department, ANZAN and the Australia and New Zealand Child Neurology Society (ANZCNS). As in recommendation nine, consultation with GPs is essential. Their feedback will ensure the form is practical, fit for purpose, and clear to the GPs who are using them.

In order to further discourage use of low-value services, the relevant information should also be included in referral pathways such as HealthPathways, on hospital websites, and the neurologist's websites.

Alternatively, the AMA suggests that a non-mandatory CDS system should be considered in place of a national standardized referral form for ordering of routine neurological tests. The AMA notes that the MBS Review Diagnostic Medicine Clinical Committee recommended the introduction of a mandatory electronic Clinical Decision Support (CDS) system Australia-wide for selected diagnostic imaging items. The AMA considers non-mandatory 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. A non-mandatory CDS system for requesting of neurological tests may be a more efficient and integrated option, particularly as this is being considered by other MBS Review Clinical Committees.

Colonoscopy

The AMA understands that the Gastroenterological Society of Australia (GESA) has had discussions with yourself as Chair of the MBS Review Taskforce and has provided a written response to the recommendations on the colonoscopy MBS items. The AMA calls on the Taskforce to work with GESA and other relevant organisations (eg the Australian Private Hospitals Association) on any of their outstanding concerns.

The AMA notes that the MBS Review colonoscopy recommendations have evolved greatly over the last eighteen months. In response to the current consultation on colonoscopy recommendations, the AMA is pleased to see that the previously proposed number of colonoscopy items has been dramatically reduced.

However, the colonoscopy item numbers remain linked to clinical guidelines and are 'absolute', with no room for flexibility. We reiterate that by their very nature, guidelines are prone to

continual change as clinical knowledge evolves. In ten years, we may end up with an outdated set of item numbers which bear very little semblance to best practice. As such, these guidelines should only serve to guide clinical practice, not dictate it.

Furthermore, the time-restricted nature of the colonoscopy surveillance intervals may impact on patient care. The ASGE (American Society of Gastrointestinal Endoscopy) Quality Indicators for GI Endoscopic Procedures published in Gastrointestinal Endoscopy in 2015 acknowledges that "adherence to appropriate colonoscopy surveillance intervals" is an important clinical indicator. However, it is also recommended that compliance should be greater than 90 per cent (ie. not 100 per cent). As such, there must be some provision for clinicians to deviate from the published surveillance guidelines. In reality, there are patients who will require an earlier colonoscopy than is permissible under the proposed guidelines. If a conscientious, compliant Australian colonoscopist, who performs 500 colonoscopies per year, blindly adheres to the time -restricted item numbers for surveillance colonoscopy and does not thoughtfully deviate by 10 per cent based on legitimate clinical concerns, then he/she is effectively suboptimally treating 50 patients per annum. On a national level, this is a large number of Australians who receive suboptimal care.

Orthopaedics

The Orthopaedics Clinical Committee (OCC) was assigned 594 MBS items to review, covering approximately 522,000 services and $195 million in benefits in the 2014-15 financial year. This equates to more than 10% of the total number of MBS items currently under review – a massive undertaking by a single committee.

The AMA has consulted with both the Australian Orthopaedic Association and the Australian Society of Orthopaedic Surgeons. They share with AMA a significant concern regarding the implementation of such a large and significant body of MBS items.

The AMA is aware that these organisations are responding in detail to the OCC report recommendations, reflecting their specialist expertise. We call on the Government to engage with the key stakeholders should any of these groups identify significant clinical concerns with the proposed changes to the MBS.

The AMA has been vocal about the implementation of the MBS review recommendations as the potential for unintended major financial consequences has now been seen in the implementation of the spinal surgery items released in mid-October 2018 for a 1 November commencement.

As the changes that are taking place through the MBS reviews are not straightforward "like" for "like" changes it is not possible for the AMA, private health insurers and medical practitioners to change their rates and fees without the appropriate information and an adequate timeframe.
For the spinal items this resulted in a double whammy, insurers were not ready with their benefit schedules, and insurers priced the same service under the new items at a different price due to not having the information they needed.

In spite of the work of the AMA to draw the Minister's attention to this issue there has been no announcement about how (or even if) the Government is proposing to alter its MBS implementation process.

The spinal surgery items covered 60 items and yet that has still left patients and medical practitioners out of pocket due to the chaotic implementation that resulted. Additionally, the deeply flawed process has meant that some insurers reduced their rebate levels on specific procedures, and having had this drawn to their attention after their schedules were finalised, would appear to have not reissued new rebates. This is likely to create a greater level of gap billing and has significantly undermined the faith of other specialty groups in the MBS review process.

The OCC report covers the biggest group of items yet to be implemented through the review process. As with spinal surgery the recommendations will result in creation of new payment levels for the revised items. Accordingly, the AMA calls on Government to:

- Consult with the AMA and private health insurers to understand what information they require from the review to better translation their schedules;
- Release a document that outlines exactly how the old items relate to the new items, including how the new fees relate to the old fees, and how they were determined;
- Provide an appropriate timeframe (eg at least 6 months as suggested by private health insurers at the 7 December 2018 spinal surgery implementation workshop with the Department) to allow insurers, and the AMA, to digest the changes, generate their benefit schedules, implement the changes in their system and then communicate it to the profession; and
- Uses its regulatory powers to assess how each organisation has responded to the new items to ensure that there is no deliberate profiteering resulting from this exercise.

Failure to carry out these steps will create a level of chaos and confusion that will impact thousands of patients across Australia and will lead to a far greater level of Government created out of pocket expenses than currently exists.

Yours sincerely

Dr Tony Bartone
President