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Professor Anne Duggan
Chair, Gastroenterology Clinical Committee
MBS Review Taskforce
by email: MBSTaskforceCommittees@health.gov.au

Dear Professor Duggan

Re: MBS Review Colonoscopy item consultations

Thank you for your letter dated 9 April seeking AMA feedback on the MBS Review Colonoscopy Clinical Committee's consultation on the proposed 20 new colonoscopy items. The AMA appreciates the Taskforce's engagement and opportunities to provide comment on proposed MBS changes, however given the short consultation timeframe, the AMA is only able to provide comment on the broad policy issues and provides a small sample of direct feedback from members.

MBS Reviews

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. This includes having the right mix of practising clinicians on each committee, with genuine input into a process of transparent decision making. We wish to ensure that the review process will deliver a schedule that reflects modern medical practice by identifying outdated items and replacing them with new items that describe the medical services that are provided today. In doing so, it is crucial that any savings from the MBS review be reinvested into the MBS, and that the review is not simply a savings exercise.

The AMA's approach has always been to defer feedback relating to specialty items to the relevant colleges, associations and societies (CAS). The AMA will, however, continue to comment on and respond to the broader strategic and policy aspects of the review, and where we feel there has been an issue regarding process or consultation. This is done by vetting the Clinical Committee recommendations against key principles and feedback from our internal committees and working groups.

In this particular instance, the AMA has consulted on the proposed colonoscopy changes with AMA's Medical Practice Committee and key craft group representatives and provide the following direct comment. Please note this feedback is in no way exhaustive, but illustrates some of the policy issues identified with the proposed MBS changes to colonoscopy services.

Clinical Guidelines

In our most recent submission to the Chair of the MBS Review Taskforce, Professor Bruce Robinson (27 October 2017), the AMA noted concerns relating to the use of clinical guidelines in MBS item descriptions. While the AMA supports clinical guidelines to be used as guides or explanatory support, the AMA agrees with the Gastroenterology Clinical Committee that implementing guidelines directly into item descriptions risks placing arbitrary restrictions on services and may impede on expert contemporary clinical judgement and knowledge which should be applied to individual cases. The AMA is therefore opposed to the inclusion of clinical guidelines in the use of any MBS item descriptor.

The AMA therefore does not support the use of clinical guidelines in the 20 new proposed colonoscopy item descriptions, however recognises there may be some value in providing medical practitioners with reference to guidelines in the MBS item supporting notes.

Noting the MBS Review Clinical Committees are likely to be accelerated in 2018, there are concerns a precedent to implement guidelines will encourage other MBS Review Committees to similarly include guidelines in MBS descriptions.

The AMA further provides the following feedback as illustrative of the some of the issues raised with the proposed colonoscopy changes. They should not be regarded as a full examination of the clinical issues arising from the consultation, which should be referred back to Gastroenterological Society of Australia.

Remuneration

- A suitable framework of patient MBS rebates requires that appropriate MBS items are in place. The MBS items should reflect the range of services that need to be available for patients as dictated by current best practice.
- Current best practice should be defined by the specialty referring to appropriate sources and standards as required. As to the appropriate level of MBS rebate, the AMA believes this should be determined in consultation with the relevant craft group who can provide the appropriate guidance on the training and expertise required for each item.
- The proposed colonoscopy changes dramatically expand the number of item codes (2 to 20) but they do not expand the remuneration types - the code expansion does not appear to change the underlying basis that there is a colonoscopy without polypectomy, or a colonoscopy with polypectomy, for which there is respective remuneration.
- It is cautioned that the MBS should not be expanded to collect the indication for procedures where those procedures are identical in their general nature and their rebate level.
- It is unclear if any other group of item codes in the MBS where item codes are created in this manner, and we surmise that the only logical reason for creating them is for data collection.

The AMA is aware of the work of the Australian Commission on Safety and Quality in Healthcare suggesting that there is potential over servicing in the provision of colonoscopies. If the aim of creating item codes that make specific reference to clinical guidelines is to prevent over servicing, the AMA cannot see that this would be the case as there rightly remains an option for a proceduralist to justify the colonoscopy on the grounds that the patient is symptomatic.

More work for medical practitioners

- Sub-categorisation of colonoscopy item numbers to the extent proposed may increase the administrative burden on already busy medical practitioners which could lead to increased inaccuracies.
- Whilst we note a key driver of the review is to reduce unnecessary medical services, increasing the number of service items may not have the intended result of reducing unnecessary colonoscopies, as there are foreseeable "shortcuts" that might be taken in order to minimise paperwork resulting in procedures being performed that may not fully meet the specified criteria.
- One suggestion is examining a pre-approval system, such as a centralised nationwide database of all colonoscopies performed and histology entry for the future as an alternative plan moving forwards (i.e. the United Kingdom model).

Item description for 32231

- There are issues with the wording of the proposed item descriptor for 32231:

  "Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy - for failed preparation of the colon"

- The indication for a colonoscopy isn't failed bowel preparation. It is assumed this item code is proposed to be used for an attempted colonoscopy where the bowel preparation was inadequate, although perhaps (and this is not usual) it could be for the subsequent colonoscopy which was performed because the bowel preparation for the previous colonoscopy was inadequate.
- If the aim is to provide an item code for a colonoscopy that was aborted or unable to be adequately performed because of bowel preparation the descriptor needs to more accurately reflect this.

Patient past history

- It is often difficult to accurately determine a patients' past history in an open access environment. Given the implications of non-remuneration should a patient fail to meet the criteria of one of the subgroups, procedural lists would need to be booked based on consultation with the patient.
- It is not often that GP's are aware if or when a patient has had a previous procedure and rarely document the histology. As a result, there is a likelihood of increased number of clinical consultations (MBS item 110) in order to determine appropriateness and eligibility for the referred procedure. A result of this is increased costs to the health system overall due to increased consultation billings and potential increase in wait times for colonoscopy procedures.

Large Polyp Removal

- Another issue not adequately addressed in the proposed items is the follow-up interval after large polyp removal. As reported in some of the data (e.g Michael Bourke), residual at first follow-up can be as high as 23% and so it is recommended initial follow-up at six months and then one year. Looking at the numbers, it appears only A9 fits into this category (although not strictly true if they haven't had their scope yet - it is rather risk of incomplete resection) but there does not seem to be a corresponding B item in the event of residual being present.

Thank you for the opportunity to provide feedback. Should you have any further questions, please contact Eliisa Fok, Senior Policy Adviser on 02 6270 5447 or efok@ama.com.au

Yours Sincerely,

Luke Toy
Director Medical Practice