

# **The Australian Society of Anaesthetists response to the Report from the Anaesthesia Clinical Committee October 2017**

## **Medicare Benefits Schedule Review**

**October 2018**

## Executive Summary

1. The Anaesthesia Clinical Committee (ACC) has produced a set of 67 Recommendations that will impact upon 100% of anaesthesia services in Australia, and will adversely affect the out of pocket costs for 1.2 million patients in Australia.
2. The Australian Society of Anaesthetists (ASA) has significant concerns with the following key aspects of the majority of the ACC's Recommendations:

Lack of an evidenced-based approach to modification of MBS item numbers

Inconsistencies in recommendations between Clinical Committee reports

Erosion of patient-centred care and the targeting of vulnerable patient groups such as elderly patients, sick people, pregnant women and people with mental health issues

Undermining of anaesthesia as a speciality

No evidence of a collaborative approach to engagement with the speciality in generating recommendations

No evidence of engagement with consumers

No consideration of the effects these recommendations will have on consumers, particularly on out of pockets costs, maldistribution of funding, access to essential clinical services and the unbalancing of private/public healthcare in Australia.

3. The ASA agrees with the following 19 Recommendations contained within the ACC Report. Implementation of these 19 Recommendations will balance the need to achieve the goals of the MBS review whilst protecting vulnerable patient groups, achieving individualised patient care and preserving the integrity of the specialty of Anaesthesia:

### Therapeutic and diagnostic items

Recommendation 12  
 Recommendation 15  
 Recommendation 17  
 Recommendation 18  
 Recommendation 22  
 Recommendation 25  
 Recommendation 28

### Modifying items

Recommendation 31  
 Recommendation 32

### Base and general items

Recommendation 34  
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 Recommendation 38  
 Recommendation 40  
 Recommendation 55  
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## 1. Background

The Australian Society of Anaesthetists (ASA) is a not-for-profit organization that was established in 1934 to support, connect and educate Australian anaesthetists and to maintain the highest professional standards. The ASA represents anaesthetists working in both private and public hospitals in Australia.

The Relative Value Guide (RVG), written by the ASA, is a comprehensive system for determining fees and rebates for anaesthesia that was supported by the Government and introduced into the Medicare Benefits Schedule (MBS) in 2001.<sup>1</sup> With yearly estimates of 2.7 million hospitalisations involving surgery and anaesthesia, and 59% of hospitalisations for surgery and anaesthesia occurring in private hospitals,<sup>2</sup> the ASA is deeply concerned about the impact of the recommendations made by the Anaesthesia Clinical Committee (ACC) as part of the overall MBS Review supervised by the MBS Taskforce. The ACC's recommendations will impact upon 100% of anaesthesia services in Australia, and will adversely affect the out of pocket costs for 1.2 million patients in Australia.

The aim of the MBS Review Taskforce was to deliver the four goals of affordable and universal access to healthcare, best-practice health services, value for the individual patients, and value of the health system. In addition, the ACC included the three goals of minimising ambiguity and misinterpretation of the RVG, of simplifying the RVG, and of enabling the RVG to support good data collection.

Unfortunately, there are major problems with the ACC's recommendations and these will significantly impinge upon the ability of the MBS Taskforce and ACC to achieve their key goals. Our concerns fall into the seven main areas;

1. Lack of an evidenced-based approach to modification of MBS item numbers
2. Inconsistencies in recommendations between Clinical Committee reports
3. Erosion of patient-centred care
4. Undermining of anaesthesia as a speciality
5. No evidence of a collaborative approach to engagement with the speciality in generating recommendations
6. No evidence of engagement with consumers
7. No consideration of the effects these recommendations will have on consumers, particularly on out of pocket costs, maldistribution of funding, access to essential clinical services and the unbalancing of private/public healthcare in Australia.

### 1.1 Lack of an evidenced-based approach to modification of MBS item numbers

Best-practice health services are underpinned by the use of high quality data, evidenced-based medicine and critical, innovate thinking.<sup>3</sup> The healthcare system in Australia, likewise, needs to base its modifications and improvements on an evidence-based approach within a quality and safety framework.<sup>4</sup>

The ACC reviewed 528 anaesthesia items and made Sixty-seven recommendations and yet robust, critically appraised data have not been presented for most of these recommendations. The limited bibliography only includes 29 references. The ACC does not mention NHMRC levels of evidence which is the guiding scale for contemporary clinical evidence in Australia. In addition to an overall lack of reference to evidence based on this national evidence hierarchy, some ACC recommendations are based on unquantified feedback from consumers that constitutes, at best, possible themes in qualitative research.<sup>5</sup> This is not acceptable contemporary clinical evidence. Given that there are more than 2.3 million MBS anaesthetics per year, reliable evidence (Level III) would require a survey data of about 1,500 patients and consumers on their opinions and attitudes.<sup>6</sup>

In the absence of data, recommendations have been made to change, each year, over 2.6 million pre-anaesthesia consultations, to modify the time component of 2.2 million anaesthesia services, to delete

essential services including blood transfusion,<sup>7</sup> invasive pressure monitoring,<sup>8</sup> and intrathecal and epidural analgesia for post-operative pain relief,<sup>9,10</sup> and to change the relative value of anaesthesia for 167 different types of surgery. The recommendations propose a complete overhaul of the funding of anaesthesia services provided to Australian patients. With such vast ranging implications for healthcare in Australia, such recommendations without evidence cannot be supported.

### **1.2 Inconsistencies in recommendations between Clinical Committee Reports**

Value for individual patients and value for the health system, as key goals of the MBS Review Taskforce, mean that there must be consistency in the assessment of the value and provision of the same services across disciplines. In contrast to the ACC recommendations, the Intensive Care and Emergency Medicine (ICEM) review committee have assessed that arterial/central venous continuous pressure monitoring is a valuable service that needs to be retained, and that an age modifier for patient older than 75 years be introduced.

There also must be agreement between the Clinical Committee on the drivers of growth in healthcare. Like the ACC report, the Clinical Committee reports for Renal, Dermatology, Allergy and Immunology, Pathology, Endocrinology, Intensive Care and Emergency Medicine, and Cardiology all document an increase in total benefits and an increase in number of services. However, unlike the ACC report, all six of these other reports state that the growth is largely explained by an increase per year in services per head of population. For consistency, growth in anaesthesia services should also be described in the same way, reflecting an increase per year in surgical services per head of population, along with the changing demographics of the patient population presenting for surgery and anaesthesia.<sup>11</sup> It is also essential to note that growth in anaesthesia services, and therefore expenditure, is almost entirely out of the control of anaesthetists. Anaesthetists do not generate the demand for their services.

### **1.3 Erosion of patient-centred care**

Patient centred care is the goal of contemporary healthcare.<sup>12</sup> The RVG enables patient centred care because it breaks down the components of the anaesthesia service into time units, base units dependent on the type of surgery, therapeutic and diagnostic units that cater to individual patient needs, and modifiers based on patient and surgical urgency characteristics. This facilitates the tailoring of anaesthesia care to the individual patient regardless of the type of surgery they are having. The ACC's recommendations to bundle anaesthesia services, delete therapeutic and diagnostic services, and to remove modifiers erode the principle of patient-centred care and represent a retrograde step in healthcare in Australia.

### **1.4 Undermining of anaesthesia as a speciality**

Anaesthesia in Australia is a speciality that leads the way in quality and safety, innovation and research, and data collection and monitoring of patient outcomes.<sup>13</sup> The poor language and tone of the ACC report undermines the integrity of anaesthesia. The non-evidenced based recommendations to change consultation items, time items, therapeutic and diagnostic items, patient modifiers, and base items undermines the independence of anaesthesia and devalues the comprehensive range of clinical skills that anaesthetists use daily. Deletion of key anaesthesia items undermines the ability to undertake high quality data collection thereby preventing the ACC's goal of improving data collection through its recommendations.

### **1.5 No evidence of a collaborative approach to engagement with the speciality**

Collaboration with experts in the field is essential in the development of evidenced-based, high quality guidelines and recommendations in healthcare.<sup>14</sup> In contrast to most other Clinical Committees, the ACC has not included the current president or vice-president of ANZCA or the current president or vice-presidents of ASA, or any senior clinician researcher or academic. Importantly key experts conversant in the RVG have not

been involved in its revision. Poor engagement with leaders has led to recommendations that demonstrate a lack of understanding of the RVG and potentially damaging effects to the healthcare system if implemented.

### **1.6 No evidence of engagement with consumers**

Engagement with consumers is core to any improvement strategies in healthcare.<sup>15,16</sup> The ACC report fails to present any evidence of appropriate engagement with consumers, fails to present data from consumer groups and does not present data from publications based on the experience of consumers. Anecdotal statements presented by individuals on the ACC attesting to the views of consumers cannot be used to justify changes to Australia's healthcare system.

### **1.7 The effects on consumers and the healthcare system**

Paucity of economic modelling or flawed economic modelling used throughout the ACC report means that consumers will face increased out of pocket costs. If the proposals are implemented The ACC recommendations shift anaesthesia services from individualised care to bundled care through the packaging of therapeutic and diagnostic items with base items. This will lead to a maldistribution of funding. This will especially disadvantage elderly patients, sicker patients, people with mental health issues, and pregnant women. Any increased out of pocket costs have the potential to unbalance the healthcare system by reducing the value of private health insurance and reducing access to essential medical services. This may lead consumers to give up their private health insurance or not take it out in the first place leading to a shift to public hospital care.<sup>17</sup> Reduced throughput in private hospitals may also be detrimental to the sector.

The private/public balance is important in healthcare in Australia as it facilitates affordable and accessible healthcare for all Australians.<sup>18</sup> This is particularly important currently in maternity services where women are choosing to not take out private health insurance or give it up after their first baby. Any further disincentives to the uptake of private health insurance by young women, contributed to by the ACC recommendation to reduce rebates for caesarean section anaesthesia, may further threaten this balance. Increasing the burden of healthcare in the public sector may seriously impact upon timely access to services, and further consumer dissatisfaction both of which prevent the achievement of the MBS Review Taskforce goals.<sup>19</sup>

In the following section, each recommendation will be analysed. For each recommendation four domains will be presented:

- The current situation and evidence
- An analysis of the draft recommendation and anticipated problems
- The impact of the recommendation
- An assessment of the recommendation based on the goals of the MBS Taskforce and the aims of the Anaesthesia Clinical Committee (ACC)

As a final summary an appendix (Appendix 1) is presented listing the 19 Recommendations that the ASA agrees with.



## 2. Consultation items

### 2.1 Recommendation 1 Pre-anaesthesia consultations

#### **Pre-anaesthesia consultation items 17610, 17615, 17620, 17625**

- △ *Restructure these items into three new items. For the purposes of this report, these new items are referred to as Item 1, Item 2 and Item 3.*
- △ *Item 1 should maintain the same schedule fee as is currently applied to item 17610 and should have the characteristics listed in Table 4.*
- △ *Items 2 and 3 should have their schedule fees assessed in light of the higher requirements placed on clinicians, however the Committee has referred these items along with item 1 to the Consultation Services Clinical Committee for review and assessment.*

### ASA Response

Australia is one of the safest places in the world to undergo anaesthesia. Fundamental to this safety is an appropriate and timely pre-anaesthesia consultation.<sup>20</sup> Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) both have guidelines and position statements on the pre-anaesthesia consultation.<sup>21-23</sup> The current consultation items in the RVG are patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards. Each of the current consultation items (17610, 17615, 17620, 17625) include a time component, as well as clinical components, and three (17615, 17620, 17625) specify documentation requirements.

Recommendation 1 proposes significant changes to anaesthesia consultation items based on an absence of evidence, with heavy reliance on anecdote, and a lack of knowledge regarding the current system. Specifically, the ACC report is incorrect in stating that the current consultation items are purely time based. No data are presented in the report regarding the number and type of complaints regarding pre-anaesthesia consultations.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 2,489,313 anaesthesia consultation services in Australia with 91% of these consultations being 17610.<sup>24</sup> The changes proposed in Recommendation 1 will impact upon nearly 2.5 million patient consultations, will require major changes to billing software, and are unjustified in the absence of evidence of a problem with current consultations.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 1 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 1.

## 2.2 Recommendation 2 Telehealth consultation

### **Telehealth Consultation Item 17609**

△ *Change the numbering in clause (b) to reflect new item numbers for pre-operative anaesthesia consultations.*

### **ASA Response**

Geographical issues are significant in Australia which has a diverse spread of healthcare services and important issues related to rural and remote health workforce. Approximately one third of Australia's population live in regional, rural and remote areas with many Aboriginal and Torres Strait Islander people living in these areas.<sup>25</sup> Telemedicine is an essential method of removing barriers to accessing medical services. The current telemedicine consultation item incorporates the current consultation items that are patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards.<sup>21-23</sup>

Data from Medicare items processed for the time period July 2016 to June 2017 documented 344 telehealth consultation services in Australia.<sup>24</sup> The changes proposed in Recommendation 2 complicate and de-incentivise the delivery of telehealth. The change to this item are in direct opposition to the statement on the MBS and telehealth website which states that there will be no changes to Telehealth Medicare Benefit Schedule (MBS) items.<sup>26</sup> Instead of complicating telehealth consultations the MBS review should be encouraging the use of this item to facilitate better access to healthcare by Australians living in rural and remote areas.

This recommendation does not fulfil any of the four MBS Taskforce's goals, in particular, facilitating universal access to healthcare, and with respect to the ACC's aims Recommendation 2 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 2.

## 2.3 Recommendation 3 Anaesthesia consultation - Brief

### **Anaesthesia Consultation 17640**

- △ *Align the descriptor for item 17640 with proposed Item 1 for pre-anaesthesia consultations.*
- △ *The descriptor should:*
  - *Include specific actions the clinician should take, including a review of medications and relevant investigations, as well as a discussion with the patient and/or carers.*
  - *Require the clinician to log appropriate documentation within the patient’s medical record.*
- △ *The proposed descriptor is as follows:*
  - *Professional attendance by a specialist anaesthetist in the practice of anaesthesia where the patient is referred to him or her – a brief consultation involving a short history, including review of medications and relevant investigations, and limited examination, including appropriate documentation within the patient’s medical record, and includes discussion with the patient and/or carers, not being a service associated with a service to which items 2801– 3000 apply.*

### **ASA Response**

Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) both have guidelines and position statements on the pre-anaesthesia consultation.<sup>21-23</sup> The current consultation items in the RVG are patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards.<sup>21-23</sup> The current consultation item (17640) includes a time component, as well as a clinical component.

Recommendation 3 proposes significant changes to this consultation item based on an absence of evidence with heavy reliance on anecdote, and a lack of knowledge regarding the current system.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 65,367 anaesthesia consultations, separate from anaesthesia, in Australia.<sup>24</sup> The changes proposed in Recommendation 3 will impact upon over 65,000 patient consultations, will require major changes to billing software, and are unjustified in the absence of evidence of a problem with current consultations.

This recommendation does not fulfil any of the four MBS Taskforce’s goals and with respect to the ACC’s aims Recommendation 3 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 3.

## 2.4 Recommendation 4 Anaesthesia consultations - 15 to 45 minutes

### **Anaesthesia consultation items 17640, 17650**

- △ Consolidate items 17645 and 17650. The consolidated item should align with proposed Item 2, valued higher than the rate currently applied to either item. The Committee has referred this item to the Consultation Services Clinical Committee for review and assessment of the schedule fee.
- △ The descriptor should:
  - Be more specific in terms of what is required of anaesthetists for this consultation item. This includes a review of medications and relevant investigations, examination of multiple systems, potentially including consultation with colleagues, and a discussion with the patient and/or carers that ensures the patient understands why the consultation is required, gives the patient an opportunity to ask questions and respects the patient's culture and beliefs.
  - Require the clinician to formulate a patient management plan within the patient's medical record.
  - Specify that the item is for consultations where the patient has been referred to the anaesthetist.
- △ The duration of the item should mirror Item 2 in the pre-anaesthesia consultation items, which states that the consultation should be of more than 20 minutes' duration.
- △ The proposed descriptor is as follows:
  - Professional attendance by a specialist anaesthetist in the practice of anaesthesia (where the patient is referred to him or her) —
  - A consultation involving a selective history, including review of medications and relevant investigations, examination of multiple systems, may include consultation with colleagues, and includes the formulation of a documented patient management plan within the patient's medical record and includes discussion with the patient and/or carers that ensures the patient understands why the consultation is required, gives the patient an opportunity to ask questions and respects the patient's culture and beliefs —
  - And of more than 20 minutes' duration, not being a service associated with a service to which items 2801–3000 apply.

## ASA Response

Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) both have guidelines and position statements on the pre-anaesthesia consultation.<sup>21-23</sup>

The current consultation items in the RVG are patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards.<sup>21-23</sup> The current consultation items (17645, 17650) include a time component, as well as a clinical component and a documentation requirement.

Recommendation 4 proposes significant changes to this consultation item based on an absence of evidence, with heavy reliance on anecdote, no evidence of a problem with the current item numbers and a lack of knowledge regarding the current system.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 4 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 4.

## 2.5 Recommendation 5 Anaesthesia consultation - Longer

### **Anaesthesia Consultation item 17655**

- △ *Change the descriptor and schedule fee.*
- △ *The descriptor should:*
  - *Be more specific in terms of what is required of anaesthetists for this consultation item. This includes a review of medications and relevant investigations, an examination of multiple systems, potentially including consultation with colleagues, and a discussion with the patient and/or carers that ensures the patient understands why the consultation is required, gives the patient an opportunity to ask questions and respects the patient’s culture and beliefs.*
  - *Require the clinician to formulate a patient management plan within the patient’s medical record.*
  - *Specify that the item is for consultations where the patient has been referred to the anaesthetist.*
- △ *The schedule fee should be increased to align with proposed item 3 for pre-operative consultations. The Committee has referred this item to the Consultation Services Clinical Committee for review and assessment of the schedule fee.*
- △ *The duration of the item should reflect Item 3 in the pre-anaesthesia consultation items, which states that the consultation should be longer than 45 minutes.*
- △ *The proposed new descriptor is as follows:*
  - *Professional attendance by a specialist anaesthetist in the practice of anaesthesia (where the patient is referred to him or her)*
  - *A consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - and of a minimum discussion length of 45 minutes’ duration, not being a service associated with a service to which items 2801–3000 apply*
  - *A consultation involving a comprehensive history and examination of multiple systems and the formulation of a documented patient management plan within the patient’s medical record, following discussion with relevant health care professionals, involving medical planning of high complexity, and includes discussion with the patient and/or carers that ensures the patient understands why the consultation is required, gives the patient an opportunity to ask questions and respects the patient’s culture and beliefs.*

## ASA Response

Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) both have guidelines and position statements on the pre-anaesthesia consultation.<sup>21-23</sup>

The current consultation items in the RVG are patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards.<sup>21-23</sup> The current consultation items (17655) include a time component, as well as a clinical component and a documentation requirement.

Recommendation 5 proposes significant changes to this consultation item based on an absence of evidence, with heavy reliance on anecdote, no evidence of a problem with the current item numbers and a lack of knowledge regarding the current system. Respecting a person's culture and belief is fundamental to being a doctor in Australia and this principle applies to all MBS services where there is a patient-doctor relationship. Including a specific statement about this with this item is inappropriate, unnecessary and reflects a paternalistic approach to engaging with the specialty that is retrograde.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 5 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 5.

## 2.6 Recommendation 6 Anaesthesia consultation - Patient in labour

### **Anaesthesia Consultation Item (in-labour) 17680**

△ Change the descriptor.

△ The descriptor should:

- Include specific actions that the anaesthetist must take in order for a consultation to qualify for a rebate under this item. This includes a brief medical history and examination, a review of medications and relevant investigations, and the provision of written or verbal information, ideally prior to the discussion, which sets out the details of the risks and benefits of the procedure.
- Specify what the anaesthetist should speak about with the patient (including the key elements of the written or prior information), and that the patient and/or carer should be given the opportunity to ask questions.

△ The proposed descriptor is as follows:

- Professional attendance by an anaesthetist in the practice of anaesthesia
- A consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801–3000 apply.

*The consultation includes a brief medical history and examination, including review of medications and relevant investigations. The patient and/or carer are provided with written or verbal information, ideally ahead of any discussion, which sets out details of the risks and benefits of the procedure.*

*The anaesthetist has a discussion with the patient or carer that recaps the key elements of the written or prior information, gives the patient and/or carer the opportunity to ask questions, respects the patient's culture and beliefs, and establishes consent for the procedure.*

*The relevant elements of history, examination and discussion are documented in the patient's medical record.*



## ASA Response

Australia is one of the safest places in the world to give birth.<sup>27</sup> Underpinning this safety is the quality anaesthesia services performed by highly trained anaesthetic consultants and GP anaesthetists. Major regional blockade, preceded by an anaesthetic consultation, is routinely used in 27% of women who give birth vaginally.<sup>28</sup> The ACC has not presented any data indicating that there is a problem with the anaesthetic consultation that occurs for women in labour.

The RANZCOG/ANZCA joint position statement<sup>29</sup> and ANZCA's professional standard document on the management of major regional analgesia<sup>9</sup> both outline the process and requirements for consent prior to major regional blockade in pregnant women. In particular, the ANZCA document states that consultation prior to the initiation of labour analgesia may be challenging as urgent pain relief is often required and the level of distress in the pregnant woman (and often also in her support person/people) is extreme. The current descriptor for the consultation is necessarily broad enough to include the range of situations that are commonly encountered by an obstetric anaesthetist prior to initiation of labour analgesia.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 25,812 anaesthesia consultations prior to initiation of analgesia for a woman in labour, in Australia.<sup>24</sup> Any changes proposed by the MBS review must be based on best practice and evidence, and must not threaten timely access to services. The changes proposed in Recommendation 6 place unnecessary and unrealistic barriers to timely initiation of analgesia for pregnant women by mandating what is to be covered in the consultation including reviewing, with the woman, the prior information she has received. This recommendation will impact upon over 25,000 pregnant women possibly leading to significant delays in achieving analgesia, and or increased out of pocket costs because the requirements to claim the item are impossible to meet due to the woman's circumstances. Timely and effective pain relief is a universal human right.<sup>10,30</sup> Recommendations that interfere with the timely provision of safe pain relief in pregnant women, or that disadvantage women financially, cannot be supported.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 6 does not reduce ambiguity and misinterpretation of the RVG, does not simplify the RVG, and does not improve the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 6.

## 2.7 Recommendation 7 Anaesthesia consultation - Pre-hospital

### **Anaesthesia Consultation pre-hospital item 17690**

△ Change the descriptor so that it does not specify a service duration.

△ The proposed descriptor is as follows:

- Where a pre-anaesthesia consultation covered by an item in the range 2–3\* is performed in rooms if:  
(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; not being a service associated with a service to which items 2801–3000 apply.

\* The item numbers listed in the descriptor should be modified if the Committee's other recommendations for the new pre-operative consultation items are implemented.

### **ASA Response**

Australia is one of the safest places in the world to undergo anaesthesia. Fundamental to this safety is an appropriate and timely anaesthesia consultation.<sup>20</sup> This may occur prior to an admitted episode of care and may enable patient optimisation and risk reduction strategies to be implemented. It also allows information to be given to the patient before the day of surgery allowing them to reflect and further question the information if they so desire. This consultation type is to be encouraged. The Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) both have guidelines and position statements on the pre-anaesthesia consultation.<sup>21-23</sup> The current consultation item (17690) in the RVG is patient-centred, address risk, are tailored to complexity of patient and surgery, and comply with these professional standards.

Recommendation 7 proposes significant changes to this consultation item based on an absence of evidence, with heavy reliance on anecdote, no evidence of a problem with the current item number and a lack of knowledge regarding the current system.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 7 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 7.

### 3. Time Items

#### 3.1 Recommendation 8 Recording start and finish times

##### **Recording start and finish times**

△ Record the start and end times for all procedures billed under the RVG. The start and end times should reflect the anaesthesia time, which the Committee recognises may differ from the times recorded for other purposes (for example, surgical time or procedure room time).

##### **ASA Response**

Start and end times are not recorded by any other discipline and is therefore an inconsistent recommendation compared with other Clinical Committee reports. No evidence is presented for the benefit of including this additional data. Regarding accuracy, times on hospital clocks are widely variable, and as such these times would be impossible to verify.<sup>31</sup> Patients would be largely amnesic for the duration of their procedure so are unaware of start and finish times and knowing this information provides nothing to the consumer, other than to tell them how long their procedure was. This recommendation places an unnecessarily high administrative burden on anaesthetists, and on no other specialists. The Principles and Rules Committee needs to be consistent with all of the specialities therefore if this is introduced for anaesthesia it must be introduced for all specialities.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 8 increases complicates the RVG, and has not effect on the RVG to support good data collection. The ASA therefore rejects Recommendation 8.

### 3.2 Recommendation 9 Five-minute increments

#### **Five-minute increments**

- △ *Rebate all time items in five-minute increments.*
- △ *Introduce five-minute-increment time items for procedures over 120 minutes' duration.*
- △ *Introduce this recommendation as an interim measure, with the end goal of moving to one minute increments for time item billing.*

#### **ASA Response**

The ASA recognises the importance of time items and was instrumental in ensuring these were included in the RVG when this was introduced in 2001. Time items ensure that each individual patient's rebate is accurately allocated, according to the exact nature of the anaesthesia service performed, rather than an estimated average. Anaesthesia time items are essential in ensuring such accuracy.

Recommendation 9 is to rebate all time items in five-minute increments. One reason for this is to address the spike pattern observed in anaesthesia times. The spike pattern in anaesthesia time items is stated as a concern of the ACC. The ACC states that inaccurate claims for time units, based on either upcoding or downcoding acts to reduce the quality of data collected by the MBS. This is no evidence presented to support this assertion. Furthermore, the advantages of knowing the time of an anaesthetist's service to the nearest five minutes are not presented. It is likely that there is no additional benefit. The plan to progress to recoding anaesthesia times to one-minute increments is irrational.

Regarding the spike pattern, this has been evident since the introduction of the RVG in 2001. This spike pattern was expected and the value of the RVG unit was set at a lower value than what it would have been, if an even distribution of time items was predicted. Therefore concerns regarding the spiky time pattern are unfounded and there is no need for five-minute time items in order to assist data analysis. At a recent meeting, the MBS Taskforce Chair made it clear that he believed that these data are irrelevant and not used in any constructive way. The Department of Health has stated that increments of less than 15 minutes are unnecessary.

An alternative solution to the one proposed by the ACC is to remove all five-minute time items from the MBS, and that one item apply to each 15-minute interval up to an anaesthesia time of two hours. This will simplify the system by removing 16 items from the MBS.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 9 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and has no impact on the RVG to support good data collection. The ASA therefore rejects Recommendation 9.

### 3.3 Recommendation 10 Time item unit values

#### **Time Item unit values**

- △ *Item 23010: no change.*
- △ *Items 23021-23023: In conjunction with Recommendation 9 (Section 5.2) to introduce five minute increments for rebates, rebate each five-minute item at one third of a basic unit (currently \$6.60) for procedures of 16-30 minutes in duration.*
- △ *Items 23031-23083: For procedures taking between 31 and 120 minutes, introduce a rebate rate of one half of a basic unit (currently \$9.90) per five-minute increment.*
- △ *Items 23083-24136: For procedures taking 121 minutes or longer, introduce a rebate rate of two thirds of a basic unit (currently \$13.20) per five-minute increment.*
- △ *The proposed fee schedule is outlined in Table 13.*

#### **ASA Response**

Recommendation 10 proposes significantly increasing the complexity of time items including using a subdivision of one third of a basic unit.

A far more logical proposal would be to adopt a more straightforward approach:

- the deletion of time items 23021 – 23083,
- 15 min items up to 120 mins (x7 new items every 15 mins from 30-120 min)
- 5 min items from 4 hrs to 24 hrs (x132 new items for every 5 mins from 4-24 hrs)

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 10 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and has no impact on the RVG to support good data collection. The ASA therefore rejects Recommendation 10.

### 3.4 Recommendation 11 Time item descriptors

#### **Time Item descriptors**

- △ *Change all descriptors for all time items to allow co-claiming with a new item 252XX (recommended in Section 7.1.3), which is for “assistance in the management of elective anaesthesia in connection with a service described in item 18233.”*
- △ *The proposed descriptor is as follows:*
  - Anaesthesia, perfusion or assistance at anaesthesia —*
  - a) *Administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or*
  - b) *Perfusion performed in association with item 22060; or*
  - c) *For assistance at anaesthesia performed in association with items 25200 to 25205 or in connection with item 18233.*

*For a period of:*

*(XX).*

#### **ASA Response**

This recommendation incorporates the proposed changes to all time items. This recommendation does not fulfil any of the four MBS Taskforce’s goals and with respect to the ACC’s aims Recommendation 11 increases ambiguity and misinterpretation of the RVG, complicates the RVG, and has no impact on the RVG to support good data collection. The ASA therefore rejects Recommendation 11.

## 4. Therapeutic and Diagnostic Items

### 4.1 Recommendation 12 Intrathecal and epidural analgesia

#### ***Intrathecal and Epidural Items***

- △ *Change the descriptors for items 18216, 18219, 18226 and 18227 in order to specify that these items now cover combined spinal-epidural infusions, as well as intrathecal and epidural infusions.*
- △ *The new descriptors are as follows:*
  - *18216: Intrathecal, combined spinal-epidural (CSE) or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)*
  - *18219: Intrathecal, combined spinal-epidural (CSE) or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)*
  - *18226: Intrathecal, combined spinal-epidural (CSE) or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.*
  - *18227: Intrathecal, combined spinal-epidural (CSE) or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.*
- △ *Introduce a rule for items 18216 and 18226 so that either item may only be charged by any one anaesthetist for any one patient for any one attendance, regardless of the technique used.*
- △ *Introduce explanatory notes for items 18216 and 18226 to specify that one attendance means that the anaesthetist cannot claim either of these items more than once if the anaesthetist must come back to readjust the item. The anaesthetist must have at least “left the environs” to be able to claim this item for another attendance.*

#### **ASA Response**

Intrathecal, combined spinal-epidural (CSE) and epidural analgesia are common contemporary forms of major regional analgesia and are based on a robust evidence base.<sup>32</sup> Recommendation 12 improves the descriptors for these items and clarifies the situations in which they can be used. However, the ACC overlook a basic principle, in the final dot point of the recommendations. Anaesthetists do not “come back to readjust the item”. Anaesthetists provide services, not “items”. MBS items provide rebates to patients for these services. The ACC also appears unaware that an anaesthetist’s return to a patient for “readjustment” is already covered by MBS items 18222 and 18225.

This recommendation however does not impact on access to services and reflects best practice thereby fulfilling any two of the MBS Taskforce’s goals and with respect to the ACC’s aims Recommendation 12 reduces ambiguity and misinterpretation of the RVG, simplifies the RVG, and maintains the ability of the RVG to support good data collection. The ASA therefore supports Recommendation 12.

## 4.2 Recommendation 13 Blood transfusion

### **Blood transfusion item 22002**

△ *Restrict item 22002 (administration of blood or bone marrow) to massive transfusions only, using the following proposed descriptor:*

- *Administration of blood or bone marrow already collected when administered as part of a massive transfusion, defined as a transfusion of greater than 50% of blood volume within a four hour period of more than 100% of blood volume in 24 hours in adults, or as a transfusion of more than 40mL blood/kg in children, when performed in association with the administration of anaesthesia. (11)*

### **ASA Response**

Safe blood transfusion is an essential and lifesaving service in Australia. The National Blood Authority provides evidence based guidelines, supporting best practice, for the appropriate use of blood in particular the appropriateness of a single transfusion of one unit of blood.<sup>7</sup> Administration of blood during anaesthesia is a procedure that carries additional risk and responsibilities, and there is the additional requirement for patient consent.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 19,874, blood transfusion items in Australia.<sup>24</sup> Disaggregated data demonstrates that young women require more blood than young men due to the effect of childbirth and major obstetric haemorrhage where approximately 1.6% of pregnant women will require a blood transfusion around the time of birth.<sup>28</sup> As both men and women age the requirement for a blood transfusion during surgery increases reaching a peak in adults between the ages of 65 – 74 years. Comparing data from 10-years prior, the total number of blood transfusions was 21% higher in 2006-2007 at 25,284. Therefore, despite an increase in the population, an aging population and an increase in surgical activity, there has been a significant decrease in the use of blood transfusions, consistent with the speciality appropriately following best practice and current evidence based guidelines.

Recommendation 13 proposes significant restrictions to the funding of safe blood transfusions. No valid reason is presented for this and the ACC having disregarded the current evidence base, have failed to review published data in particular disaggregated data, and have ignored best practice guidelines.

The changes proposed in Recommendation 13 will impact nearly 20,000 Australians who, by definition, are unwell enough to require a blood transfusion. This recommendation does not fulfil any of the four MBS Taskforce's goals. It is not evidenced based and does not reflect best practice. With respect to the ACC's aims Recommendation 13 reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 13.



### 4.3 Recommendation 14 Fiberoptic intubation

#### **Fiberoptic intubation item 22007**

- △ *Change the item descriptor to restrict use of item 22007 to prior to the induction of anaesthesia.*
- △ *Introduce a rule for this item requiring the anaesthetist to provide a letter to the patient and/or carer and the family doctor that explains why awake flexible fiberoptic intubation was necessary, as well as the implications for future anaesthesia management.*
- △ *The proposed descriptor is as follows:*
  - *ENODTRACHEAL intubation prior to the induction of general anaesthesia with flexible fiberoptic scope associated with a difficult airway. The patient and nominated family doctor are provided with a letter from the anaesthetist (if such a letter has not been received as a result of a prior encounter) explaining the clinical indication for the procedure, and implications for future anaesthesia care.*

#### **ASA Response**

Endotracheal intubation with a flexible fiberoptic intubation to manage a person with a difficult airway is recommended by ANZCA and the Difficult Airway Society.<sup>33-35</sup> A person with a difficult airway is a high risk patient. Anaesthesia related patient morbidity and mortality occur if a person with a difficult airway is managed incorrectly.<sup>20</sup>

Item 22007 is currently appropriately restricted to the use of a flexible fiberoptic scope in a person with a difficult airway which, by definition, is a high risk clinical situation. This may be an anticipated difficult airway detected prior to anaesthesia. Alternatively it may occur once the person is anaesthetised and there are difficulties providing safe and effective breathing techniques to the patient.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 2,414 fiberoptic intubation items in Australia.<sup>24</sup> Increases in item 22007 over the last 10 years can easily be explained by a combination of increased awareness of the Difficult Airway Society's recommendations for the management of a person with a difficult airway, more widespread availability of this essential piece of airway equipment, and a changing Australian demographic with a significant increase in obesity contributing to airway difficulties. The use of this item therefore reflects evidence based guidelines and best practice. Recommendation 14 proposes significant restrictions to the funding of managing patients with difficult airways. The restriction made for fiberoptic intubation by the ACC is not based on any valid reasons, will disadvantage people who are high risk patients, and has been made with a disregard of the current evidence base and an ignorance of best practice guidelines.

The changes proposed in Recommendation 14 will impact nearly 2,500 Australians who, by definition, are high risk patients. This recommendation does not fulfil any of the four MBS Taskforce's goals. It is not evidenced based and does not reflect best practice. With respect to the ACC's aims Recommendation 14 reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 14.

#### 4.4 Recommendation 15 Central venous catheterisation

##### **CVC item 22020**

△ Ask the Intensive Care and Emergency Medicine Clinical Committee to align the MBS fees for items 22020 and 13815, resulting in a revised fee of \$79.20 for item 13815. (The current fee is \$85.25.) The Chair of this Committee would submit the request in writing.

##### **ASA Response**

Central venous catheterisation (more commonly known as a central line) is a highly skilled procedure required for patient, surgical or anaesthesia reasons during anaesthesia, and is also used in intensive care for ongoing management of the patient.<sup>8,36</sup> The advantages of a central line are that it provides central venous pressure monitoring data which help guide individual therapies for the patient and it also provides central access to the blood stream enabling uninterpreted administration of medications. This is important because there are some medications that cannot be safely given through a smaller vein in the hand and arm. Medications administered via a central line include medications to help the heart contract and to maintain blood pressure.

In this recommendation the ACC state that doctors will use 13815 (annual growth 12.0%) rather than 22020 (annual growth 1.9%) because 13815 has a higher MBS Fee. Most patients are insured. Using Medibank as an example, they pay \$105.40 for 13815, and \$130.80 for 22020. Their argument that people will use 13815 to make more money is illogical.

It is logical, however to align the MBS fees for the items for central venous catheterization in Anaesthesia, and Intensive Care and Emergency Medicine.<sup>37</sup> The practice of central venous catheterisation is evidence based and follow best practice. The changes proposed in Recommendation 15 will not impact on patients undergoing anaesthesia. This recommendation fulfils the MBS Taskforce's goals of an evidenced based approach to assessment and does reflect best practice. With respect to the ACC's aims Recommendation 15 supports the ability of the RVG to support good data collection. This recommendation also supports consistency between the Clinical Committee's recommendations and a sensible assessment of item numbers for the same procedures. The ASA therefore supports Recommendation 15.

#### 4.5 Recommendation 16 Regional or Field nerve block

##### **Regional or Field nerve block items 22040, 22045, 22050**

- △ Consolidate items 22040, 22045 and 22050 into a new item for plexus or nerve blocks in the lower leg or forearm.
- △ The proposed descriptor is as follows:
  - Introduction of a plexus or nerve block in the lower leg or forearm with/without a catheter being inserted
- △ The new item should be valued at two basic units for blocks with no catheter and 4 basic units for blocks with a catheter. If patients are having bilateral surgery a second block would attract benefits of 50% of the schedule fee. Only one services should be claimed per patient.

#### **ASA Response**

The use of plexus or nerve blocks in the upper and lower limbs for postoperative analgesia is supported by evidence and reflects best practice as it is part of a multimodal analgesia technique. Access to timely and safe pain relief is a fundamental human right and these blocks support this right. Additional technical skills are required to perform a major plexus or nerve block in upper or lower limb and further skills are required to insert a catheter in these situations. It is logical consolidate the items 22040, 22045 and 22050 and to include in the new item the upper limb blocks however there are some concerns with this Recommendation. This Recommendation only covers upper and lower limb plexus or nerve blocks. It does not cover blocks like paravertebral blocks for breast surgery, which is well supported by evidence and should be encouraged.

This recommendation does not fulfil the MBS Taskforce's goal of an evidenced based approach to assessment of the relative value of item numbers. The ASA therefore rejects Recommendation 16 in its current form.

## 4.6 Recommendation 17 Intraoperative transoesophageal echocardiography

### ITOE item 22051

△ Introduce a rule setting out the credentials required to claim item 22051. The rule would implement the following principle:

- The item is payable where the provider is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. The Australian and New Zealand College of Anaesthetists (ANZCA) has published policy on the appropriate credentialing for peri-operative cardiac ultrasound services, such as

*the Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults. As noted by ANZCA, examples of appropriate required credentials include a university certificate-level qualification in goal-directed cardiac ultrasound and a diploma in diagnostic ultrasound focused on echocardiography from the Australasian Society for Ultrasound in Medicine, or the equivalent.*

### ASA Response

Intraoperative transoesophageal echocardiography is an advanced skill which is evidence based and forms part of best practice management of high risk patients.<sup>8</sup> Recommendation 17 introduces a rule to ensure that appropriate credentialing is in place in order to claim this item.<sup>38</sup>

This recommendation fulfils the MBS Taskforce's goals of an evidenced based approach to assessment of item numbers, does reflect best practice and modernises the RVG. With respect to the ACC's aims Recommendation 17 supports minimising ambiguity and misinterpretation of the RVG and the ability of the RVG to support good data collection. The ASA therefore supports Recommendation 17.

#### 4.7 Recommendation 18 Autologous blood transfusion

##### **Blood transfusion item 22001**

△ *Delete item 22001.*

##### **ASA Response**

Intraoperative haemodilution (acute normovolaemic haemodilution) as part of a surgical blood conservation technique is what is being referred to in this item. Item 22001 does not refer to the technique of pre-operative autologous blood donation as is stated in the ACC's rationale for deletion of this item. Acute normovolaemic haemodilution (ANH) may minimise the risks of allogenic blood transfusion and reduce the amount of allogenic blood transfused.<sup>39-41</sup> It requires additional skill and expertise and is an important option of care for Jehovah's Witnesses who will accept this form of blood conservation and administration.

This technique is now rarely used and the ASA therefore supports Recommendation 18.

#### 4.8 Recommendation 19 Double Lumen tube insertion

##### **Double Lumen tube - 22008**

△ *Delete item 22008*

##### **ASA Response**

Double lumen endobronchial tubes are used in thoracic surgery and enable the safe administration of one-lung ventilation.<sup>42</sup> The insertion of a double lumen endobronchial tube requires additional skill and is part of a subspecialised anaesthesia technique. One-lung ventilation is supported by evidenced based guidelines and is allows best practice anaesthesia in the area of thoracic surgery.<sup>43</sup> Thoracic surgery is not one of the common types of surgery and anaesthesia evidenced by the high-volume services addressed in the ACC report. It does not form part of normal clinical practice. One-lung anaesthesia is an advanced and specialised anaesthesia technique typically undertaken in patients with lung cancer.

The recommendation to delete this item is based on absent evidence, and the incorrect assessment that the insertion of a double lumen endobronchial tube is part of normal clinical practice. Data from Medicare items processed for the time period July 2016 to June 2017 documented 4,743 double lumen endobronchial tube items in Australia.<sup>24</sup> Therefore the impact of deleting this item will be to disadvantage patients undergoing high risk thoracic surgery who frequently have the diagnosis of cancer. This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 19 reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 19.

## 4.9 Recommendation 20 Invasive pressure monitoring

### *Invasive pressure monitoring items 22012, 22014*

△ Delete items 22012 and 22014.

#### ASA Response

Monitoring of central venous, pulmonary arterial, systemic arterial or cardiac intracavity pressure(s) is a fundamental component of safe anaesthesia in Australia.<sup>8</sup> Monitoring of these pressure do not constitute normal clinical practice and instead they are used in situations where there is increased risk, either of surgery, or due to concurrent medical problems in the patient, or due to requirements of the anaesthetic. Monitoring these pressures facilitates best practice as haemodynamic stability and tailoring of systemic and pulmonary pressures to the individual's physiology is intrinsic to safe anaesthesia practice and better outcomes for patients. The ACC has recommended deletion of these items based on an absence of evidence, heavy reliance on anecdote, and a lack of knowledge regarding the current system whereby there should be consistency between disciplines regarding the validity of services. As such pressure monitoring is also an essential part of safe and contemporary intensive care practice. Like Recommendation 15, it is also logical to align the MBS fees for the item for invasive pressure in Anaesthesia, and Intensive Care and Emergency Medicine.<sup>37</sup> Unlike the ACC who have recommended deletion of these pressure monitoring items, the Intensive Care and Emergency Medicine Clinical Committee has recommended that this item be left unchanged (item 13876). Inconsistencies in Clinical Committees approaches to exactly the same item assessment undermines the integrity of the MBS review process. The ASA would support the use of improved descriptors and explanatory notes to ensure appropriate clinical use.

Recommendation 20 to delete this item is based on absent evidence, and the incorrect assessment that the insertion invasive pressure monitors constitutes normal practice.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 20 reduces the ability of the RVG to support good data collection. This recommendation runs counter to the Intensive Care and Emergency Medicine's Clinical Committees assessment of the same item thereby undermining the integrity of the MBS review process. The ASA therefore rejects Recommendation 20.

#### 4.10 Recommendation 21 Pulmonary artery catheter insertion

##### **PA catheter item 22015**

△ Delete item 22015.

##### **ASA Response**

The use of pulmonary artery catheters (PAC) has been decreasing since the introduction of transoesophageal echocardiography however there are still conditions in which the PAC offers advantages over TOE. These conditions include the management of critically unwell patients undergoing surgery, and in patients in whom pulmonary hypertension is known or suspected.<sup>44</sup> The use of these devices is complex, with associated risks, and using these devices to measure and manage pulmonary hypertension and right heart failure is an advanced skill set required in both cardiac and non-cardiac surgery. Use of PACs is also driven by surgeons and intensivists and is still a widely used contemporary practice. It is also illogical and disrespectful to state that anaesthetists perform this high risk procedure with no clinical indication in order to optimise income.

The ACC has selectively quoted the American Society of Anesthesiologists (ASA) Choosing Wisely item. The ACC states: “The American Society of Anesthesiologists recommends against the routine use of pulmonary artery catheters with cardiac surgery”. The ASA Choosing Wisely site actually states: Don’t use pulmonary artery catheters (PACs) routinely for cardiac surgery in patients with a low risk of hemodynamic complications (especially with the concomitant use of alternative diagnostic tools (e.g. Transesophageal echocardiography (TEE)). The ASA goes on to define increased risk of hemodynamic complications as clinical evidence of significant cardiovascular disease; pulmonary dysfunction, hypoxia, renal insufficiency or other conditions associated with hemodynamic instability (e.g., advanced age, endocrine disorders, sepsis, trauma, burns). The ASA also defines cardiac surgery where use of PACs could be recommended including: coronary artery bypass grafting (CABG) with poor left ventricular (LV) function, LV aneurysmectomy, recent myocardial infarction, pulmonary hypertension, diastolic dysfunction, acute ventricular septal rupture and insertion of left ventricular assist device.<sup>45</sup> The ASA statement does not mention non-cardiac surgery, particularly managing pulmonary hypertension where the PAC is of significant benefit.<sup>46</sup> The ACC makes no mention of the fact that pulmonary artery catheterisation procedures have already been subject to a detailed assessment by the Department of Health’s Medical Services Advisory Committee (MSAC). This assessment resulted in a recommendation for no changes to be made to the relevant MBS items, including 22015. Yet, as a result of a brief analysis by ACC members the ACC has recommended a completely different course of action. The failure to even note the existence of this MSAC report, and the recommendation for deletion based on brief discussion is further evidence to support the concern of the ASA regarding the ACC’s approach. Similar to Recommendation 15, it is logical to align the MBS fees for the item for pulmonary artery catheter insertion in Anaesthesia, and Intensive Care and Emergency Medicine.<sup>37</sup> Unlike the ACC who have recommended deletion of the pulmonary artery catheter insertion item, the Intensive Care and Emergency Medicine Clinical Committee has recommended that this item be left unchanged (item 13818) as there were “no concerns raised regarding access to these items, or the safety, obsolescence, value or misuse of these items”.<sup>37</sup> Inconsistencies in Clinical Committees approaches to exactly the same item undermines the integrity of the MBS review process. This recommendation does not fulfil any of the four MBS Taskforce’s goals and with respect to the ACC’s aims Recommendation 20 reduces the ability of the RVG to support good data collection. This recommendation runs counter to the Intensive Care and Emergency Medicine’s Clinical Committees assessment of the same item thereby undermining the integrity of the MBS review process. The ASA therefore rejects Recommendation 21.

#### 4.11 Recommendation 22 Respiratory monitoring

##### ***Respiratory monitoring item 22018***

△ *Delete item 22018.*

##### **ASA Response**

Measurement of the mechanical or gas exchange function of the respiratory system is something that is incorporated into all modern anaesthesia machines and forms the basis of daily practice in anaesthesia therefore an additional item for this is unnecessary in contemporary practice. Arterial blood gas analysis for assessment of metabolic and respiratory function is commonly used in conjunction with arterial cannulation (item 22025) so is not necessary to be included here.

This recommendation fulfils the MBS Taskforce's goals of an evidenced based approach to assessment of item numbers, does reflect best practice and modernises the RVG. With respect to the ACC's aims Recommendation 22 supports minimising ambiguity and misinterpretation of the RVG. The ASA therefore supports Recommendation 22.



## 4.12 Recommendation 23 Arterial cannulation

### Arterial cannulation item 22025

△ Delete item 22025.

#### ASA Response

Arterial cannulation (more commonly known as an arterial line) is the method by which the monitoring of systemic arterial pressure, and metabolic and respiratory monitoring is achieved (item 22012, 22014). It is a fundamental component of safe anaesthesia in Australia and represents the reference standard for peri-operative blood pressure measurement.<sup>8</sup> Arterial cannulation and blood pressure monitoring provides continuous pressure measurement and is more reliable in some patients particularly obese patients. Arterial cannulation does not constitute normal clinical practice and instead it is used in situations where there is increased risk, either of surgery, or due to concurrent medical problems in the patient, or due to requirements of the anaesthetic. Arterial cannulation facilitates best practice as haemodynamic stability and tailoring of systemic pressures to the individual's physiology is intrinsic to safe anaesthesia practice and better outcomes for patients.<sup>8,36,47,48</sup> Additionally the presence of an arterial line facilitates the measurement of metabolism (pH, bicarbonate, lactate, glucose), electrolytes (sodium, potassium, chloride, calcium), haematological components (haemoglobin), and respiratory function (carbon dioxide, oxygen).

The changing demographics of Australians help to explain the use of arterial cannulation. Australians are becoming older, sicker, more obese, and have respiratory problems including obstructive sleep apnoea. Many patients are being treated for high blood pressure which is associated with instability during anaesthesia requiring closer blood pressure monitoring.

The ACC has recommended deletion of this item based on absent evidence, the incorrect assessment that the insertion of an arterial line constitutes normal practice and a lack of knowledge regarding the current system whereby there should be consistency between disciplines regarding the validity of services. As such arterial cannulation is also an essential part of safe and contemporary intensive care practice. Like Recommendation 15, it is also logical to align the MBS fees for the same item in Anaesthesia, and Intensive Care and Emergency Medicine.<sup>37</sup> Unlike the ACC who have recommended deletion of this item, the Intensive Care and Emergency Medicine Clinical Committee has recommended that this item be left unchanged (item 13842). Inconsistencies in Clinical Committees approaches to exactly the same item assessment undermines the integrity of the MBS review process.

Furthermore, deleting this item may in turn have unintended negative consequences: overuse of advanced non-invasive haemodynamic monitors leading to them becoming a standard of care in a wide range of patients and procedures leading to increased costs. With current costs for disposables alone for 112,000 non-invasive devices would be over \$13 million dollars. If 10% of all anaesthetics (MBS and non-MBS) incorporated these devices that would cost \$45 million per year. This expense is not justified as the accuracy of these devices is still unclear particularly for higher risk patients and procedures.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 23 reduces the ability of the RVG to support good data collection. This recommendation runs counter to the Intensive Care and Emergency Medicine's Clinical Committees assessment of the same item thereby undermining the integrity of the MBS review process. The ASA therefore rejects Recommendation 23.

#### 4.13 Recommendation 24 Intrathecal and epidural analgesia items

##### ***Intrathecal and epidural items 22031, 22036***

△ *Delete items 22031 and 22036.*

##### **ASA Response**

Intrathecal and epidural analgesia are common contemporary forms of major regional analgesia, are used for postoperative analgesia and are based on a robust evidence base. The item should not be used to cover intrathecal or epidural injection of substances including the use of in-situ catheters for intra-operative anaesthesia.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 91,106 initial intrathecal or epidural injections for postoperative pain management in Australia.<sup>24</sup> Disaggregated data demonstrates that the majority of these services occurred in young women between the ages of 25 – 34 years presumably in association with caesarean section surgery and childbirth. Data from Medicare items processed for the time period July 2016 to June 2017 documented 2,456 subsequent intrathecal or epidural injections for postoperative pain management in Australia.<sup>24</sup> Disaggregated data again demonstrates that 92% of these services were for young women presumably in association with caesarean section surgery and childbirth.

The recommendation to delete this item is based on absent evidence,

and will predominantly affect young women during childbirth. This will not only impact upon what is the commonest form of anaesthesia and pain relief after childbirth, but also impose an additional financial burden on young women by reducing funding for this essential service. At a time when young women are already giving up their private health insurance or not taking it up due to perceived reduced value, any change to MBS rebates in this area may impact on the private public balance that is necessary for a sustainable healthcare system.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 24 reduces the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 24.

#### 4.14 Recommendation 25 Cardioplegia

##### **Cardioplegia item 22070**

△ Delete item 22070.

##### **ASA Response**

In modern anaesthesia practice there is no requirement for this to be funded as a separate service.

The ASA therefore support Recommendation 25.

#### 4.15 Recommendation 26 Postoperative nerve block consultation

##### **New item for postop nerve block consultation**

△ Create a new item (2204X) to allow for follow-up visits by a practitioner following limb surgery to provide plexus or major nerve catheter top-up.

△ This item is intended to be used in conjunction with the new item recommended in Section 6.1.5 (which combines items 22040, 22045 and 22050 for regional or field nerve blocks).

△ The proposed descriptor is as follows:

- Follow-up visit by a practitioner to top up a catheter sited adjacent to a plexus or major nerve (see item 22040) for postoperative pain management (excluding subcutaneous field and periarticular catheters).

△ The new item should be valued at one basic unit.

##### **ASA Response**

The use of plexus or nerve blocks in the upper limbs for postoperative analgesia is supported by evidence and reflects best practice as it is part of a multimodal analgesia technique. Postoperative review of these patients is important however these reviews, if a catheter is inserted (which will be the majority of review in these cases) are already covered by items 18222/18225. The current MBS fee for 18222 is \$37.65 which is approximately 2 units. Recommendation 26 proposes that the new item will be 1 unit. This recommendation is inconsistent with 18222/18225 and is not based on evidence. Due to inconsistency with other related items, this recommendation does not fulfil the MBS Taskforce's goals of an evidenced based approach to assessment of item numbers, and modernisation of the RVG. With respect to the ACC's aims Recommendation 26 this does not support a simplification of the RVG and does not support the RVG to enable good data collection. The ASA therefore rejects Recommendation 26.

#### 4.16 Recommendation 27 Complex eye blocks

##### **New item for Complex eye blocks**

- △ *Introduce a new item to complement item 18240 in the T7 grouping, accounting for “retrobulbar or peribulbar injection of an anaesthetic agent, or another complex eye block, however named, when administered by an anaesthetist.” The new item should appear in the T10 grouping so that it may be claimed by anaesthetists under the RVG.*
- △ *Permit the new item for “retrobulbar or peribulbar injection of an anaesthetic agent, or other complex eye block, when performed by the anaesthetist” to be co-claimed with item 20142 (anaesthesia for lens surgery), when anaesthesia or sedation was also provided by that anaesthetist.*
- △ *Review the new item within two years of introduction.*
- △ *The value of this new item should be three basic units.*

##### **Rationale**

*This recommendation focuses on modernising the MBS and ensuring parity in rebates for identical procedures, regardless of the practising physician. It is based on the following.*

- △ *The Committee noted that under current Medicare rules, an anaesthetist may not co-claim a T7 item with a T10 item. The Committee felt that the rebate for anaesthesia/sedation for lens surgery should differentiate between simple sedation or anaesthesia and those cases where more complex eye blocks were provided.*

##### **ASA Response**

There is no justification for singling out this type of block and no others. Peri- and retrobulbar blocks are now infrequently used and sub-tenons anaesthesia is commonly used. The descriptor is particularly vague including ‘...or another complex eye block, however named..’ which crease ambiguity and increases discretionary use of the item. This recommendation does not guide and support appropriate and safe use of specific anaesthesia for eye surgery therefore the ASA therefore rejects Recommendation 26.

#### 4.17 Recommendation 28 Epidural blood patch

△ No change.

##### ASA Response

Epidural blood patch is a recognised treatment for post-dural puncture headache usually in association with obstetric spinal or epidural anaesthesia or analgesia.<sup>49</sup>

Recommendation 28 proposes no changes to this item. The ASA supports Recommendation 28.

## 5. Modifying items

### 5.1 Recommendation 29 ASA 3

#### ASA 3 item 25000

- △ *Extend this item to include patients with age-related frailty.*
- △ *Include in the explanatory notes specific examples of the type and level of disease covered by the item.*
- △ *Review the item descriptor 12 months after the recommended changes have been implemented. The Committee also recommends a review of patterns of claiming, as well as total claim volume and benefits.*
- △ *The proposed descriptor is as follows:*
  - *Anaesthesia, perfusion or assistance at anaesthesia:*
    - *For anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or*
    - *For perfusion performed in association with item 22060; or*
    - *For assistance at anaesthesia performed in association with items 25200 to 25205.*

*For a patient with severe systemic disease and significant functional limitation, or a patient with frailty or age-related limitation equivalent to ASA physical status III.*
- △ *The proposed explanatory notes are as follows:*
  - △ *Examples include: Poorly controlled diabetes mellitus (HbA1c > 8), poorly controlled hypertension (grade III), chronic obstructive pulmonary disease (severely limiting function), clinically severe obesity (BMI > 40), active hepatitis, implantable AICD or pacemaker dependency, moderate reduction of ejection fraction < 40%, end stage renal failure requiring dialysis, premature infant PCA < 60 weeks, myocardial infarction, or cerebrovascular accident (severely limiting function).*

## ASA Response

The ASA 3 modifier is an important modifier that identifies patients at higher risk of peri-operative morbidity and mortality requiring additional intensive peri-operative management.<sup>50</sup> Age and frailty are two separate and different variables that interact with the ASA 3 status.<sup>51,52</sup> Recommendation 29 includes frailty and age-related limitation as a modifier for ASA 3 co-morbidity and therefore includes all three modifiers together. No evidence is presented for this modification to ASA 3. Frailty is independent of age but is also not always associated with a comorbidity. Young people may also be frail (for example a young adult with cystic fibrosis). Addressing frailty as a separate item (Recommendation) would modernise the RVG and be evidenced based.

The current descriptor for this item perfectly describes the physical status of the patient to enable benefits to be payable under this item. The current descriptor refers to patients classified as ASA Class 3 – this is quite precise and is not *“too vague”* as described in the rationale for change in the report. The current item descriptor is accompanied by an explanatory note (T10.3) which provides many clinical examples of patient conditions which might meet the criteria and is not acknowledged in the ACC report. There is no evidence provided of any problems with misinterpretation of this item or any evidence of overclaiming. The ASA does not agree that *“age-related frailty”* is satisfactorily covered by this item. This view is supported by the findings of the ICEM Clinical report which stated that *““The Committee noted that patients who are very young or elderly require a greater amount of professional involvement than is reflected in the complexity-tiered base items. Age is one determinant of the level of professional involvement required and is not simply a proxy for other factors.”*

Further the statement made in the report that this change will *“reduce the likelihood that a clinician would bill multiple modifiers for an individual patient with multiple complexities that cannot be distinguished from one another”* is not only non-sensical but is made without any supporting evidence.

This change does not modernise nor simplify the MBS but coupled with the change to item 25015 (recommendation 30) will target the elderly patient population and increase their exposure to gap payments and therefore possibly reduce access to services through the MBS. The ASA therefore rejects Recommendation 29.

## 5.2 Recommendation 30 Age modifier

### Age modifier item 25015

- △ Change this item to cover patients under the age of four only.
- △ Review the new descriptor 12 months after the recommended changes have been implemented, along with patterns of claiming and any growth in total claim volume and benefits.
- △ The proposed descriptor is as follows:
  - Anaesthesia, perfusion or assistance at anaesthesia where the patient is less than 4 years of age.

### ASA Response

The current age modifier applies to patients with age 70 years or greater or for those less than 12 months of age. The current age modifiers are based on the physiological changes associated with age that are evidenced based and reflect best practice. Clearly this item is not subject to interpretation and there is no 'discretionary' component involved in its application. The ACC report states that *"advanced age is a known risk for poor procedural outcomes"* but then goes on to state that *"the majority of the Committee felt that unless older age is associated with frailty or significant co-morbidities, the anaesthetist's job is unlikely to be significantly more difficult"* These two statements are difficult to reconcile and no supporting evidence is provided. The ASA notes the findings of the ICEM Clinical report that *"Age is one determinant of the level of professional involvement required and is not simply a proxy for other factors"*.

The greater than 70 years of age modifier is logical and consistent with the increased peri-operative risk associated with anaesthesia in this age group, and the clinical skill required to deal with the general effects of ageing including all the physiological changes in all body systems and subsequent pharmacodynamic and pharmacokinetic changes.<sup>50</sup> Recommendation 30 proposes deleting the upper age limit without consideration of any evidence.

The removal of benefits for those patients aged over 70 will clearly target those patients who are older for a reduction in Medicare benefits with possible impacts on gap payments and subsequent reductions in service accessibility being possible. This reduction in benefits by removing the eligibility for this item is illogical considering the ACC acknowledges the higher risk in the older patient age group for which there is clear evidence.<sup>53</sup>

The less than 12 months age modifier is logical and consistent with the risk associated with anaesthesia in this age group, the additional skills and training required in this setting and the physiological differences between less than 12 months and greater and are supported by ANZCA Professional Document PS29.<sup>54</sup>

Recommendation 30 proposes to increase the lower age limit to children under the age of four without consideration of any evidence regarding physiological changes, additional skills, or clear benefits. Furthermore, this is likely to result in a substantial use of this item (cost to the MBS) given the number of children under four undergoing anaesthesia. There is no justification for this item change and inconsistent with ANZCA PS29.<sup>54</sup>

This recommendation does not fulfil any of the four MBS Taskforce's goals in particular value for the individual patients, and value of the health system. With respect to the ACC's aims Recommendation 30 reduces the ability of the RVG to support good data collection specifically related to age-related complications. The ASA therefore rejects Recommendation 30.



### 5.3 Recommendation 31 Assistance with epidural blood patch

#### ***New item for assistance with epidural blood patch***

- △ *Create a new item (252XX) to allow for a rebate for an assisting anaesthetist in the administration of item 18233 for epidural blood patch (EBP).*
- △ *The item should be valued at one basic unit and should be claimed in conjunction with a time item.*
- △ *The proposed descriptor is as follows:*
  - *Assistance in the management of elective anaesthesia in connection with a service described in item 18233.*

#### **ASA Response**

Epidural blood patch is a recognised treatment for post-dural puncture headache usually in association with obstetric spinal or epidural anaesthesia or analgesia.<sup>49</sup> It is a technique that requires an assistant.

Recommendation 31 introduces a new item to allow for a rebate for an assisting anaesthetist in the administration of item 18233 for epidural blood patch (EBP). Whilst this is a positive thing for patients undergoing an EBP, it demonstrates complete inconsistency with this approach. There appears to be no body of evidence reviewed that supports the change of rules for EBP. The ACC has decided to change the rules for this specific procedure and yet does not propose any changes to the services where a second anaesthetist is also required.

This recommendation however fulfils the MBS Taskforce's goals of an evidenced based approach to assessment of this item, does reflect best practice and modernises the RVG. With respect to the ACC's aims Recommendation 31 supports the ability of the RVG to support good data collection. The ASA therefore supports Recommendation 31.

### 5.4 Recommendation 32 Multiple items

- △ *No change to the items in Table 32.*

#### **ASA Response**

The ASA supports making no changes to the RVG without appropriate consultation and an evidenced based approach to reviewing item numbers. Therefore the ASA supports Recommendation 32 to make no changes to items in Table 32.

## 6. Basic unit items

### 6.1 Recommendation 33 Breast procedures

#### **Breast procedures items 20401-20406**

- △ *Items 20401, 20404, 20405 and 20406: No change to the descriptors.*
- △ *Item 20402: Add the words “including implant reconstruction and exchange” to the item descriptor. The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for reconstructive procedures on breast including implant reconstruction and exchange.*
- △ *Item 20403: Delete the words “removal of breast lump or for breast segmentectomy” from the item descriptor and specify that the item is for “axillary dissection or sentinel node biopsy.” The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for axillary dissection or sentinel node biopsy.*
- △ *Please note that these items have also been recommended for an increase in the relative values. Please refer to Section 8.2.3 for more information.*

#### **ASA Response**

The ASA supports the recommendation for the proposed change to the descriptor of item 20402. It would appear unnecessary and does not simplify the MBS but the ASA is not opposed to the change.

The ASA acknowledges that the sentinel node biopsy procedure should be included in the item descriptor for current item 20403 and the wording could be simply modified to cover this common procedure by adding the words “or sentinel node biopsy” to the existing descriptor. The ACC does not appear to have considered existing item 21610 (5 base units) which covers axillary dissection. The ASA does not believe the change in the wording affords any advantage in terms of clarity of meaning or simplification but is not opposed to the proposal.

## 6.2 Recommendation 34 Upper abdomen laparoscopy

### ***Upper abdomen laparoscopy item 20706***

△ *Change the descriptor to specify that this item includes laparoscopic cholecystectomy.*

△ *The proposed descriptor is as follows:*

- *Initiation of management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, and not being a service to which another item in this subgroup applies.*

### **ASA Response**

The ASA supports this recommendation

### 6.3 Recommendation 35 Upper GI endoscopy

#### **Upper GI endoscopy item 20740**

- △ *Change the descriptor to allow biopsies and specify that the item is for diagnostic or screening procedures.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for diagnostic or screening upper gastrointestinal procedures including biopsies.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.4 for more information.*

#### **ASA Response**

The ASA notes that this proposal is part of a re-organisation of anaesthesia for endoscopy items with the major thrust a reduction in the base unit allocation for the majority of services. For this proposal the re-organisation will result in two different items applying to services where currently one item (20740) covers the vast majority of all services. This clearly is not a simplification.

The ASA further notes that there is no substantial difference in the clinical management and risks involved for upper GI endoscopy procedures which are “diagnostic or screening” with or without biopsies or for “therapeutic procedures”. The ASA does not support a differential allocation of units for these almost identical services. This proposal does not meet the criteria of simplifying the MBS nor does it reflect modern anaesthetic practice. The ASA therefore rejects Recommendation 35.

## 6.4 Recommendation 36 Upper GI endoscopy for haemorrhage

### **Upper GI endoscopy for haemorrhage item 20745**

- △ *Change the descriptor to specify that this item is for complex and/or therapeutic procedures, and include in the descriptor examples of the types of procedure covered by this item.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for complex and/or therapeutic gastrointestinal procedures, for example endoscopic retrograde cholangiopancreatography ('ERCP'), endoscopic ultrasound ('EUS'), percutaneous endoscopic gastrostomy ('PEG insertion'), endoscopic mucosal resection ('EMR'), oesophageal or other mucosal resection, or procedures relating to gastrointestinal bleeding.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.5 for more information.*

### **ASA Response**

The ASA notes that this proposal is part of a re-organisation of anaesthesia items for endoscopy procedures with the major thrust a reduction in the base unit allocation for the majority of services. For this proposal the re-organisation will result in two different items applying to services where currently one item (20740) covers the vast majority of all services. This clearly is not a simplification of the MBS and there is no supporting evidence provided for this change.

The ASA further notes that there is no substantial difference in the clinical management and risks involved for upper GI endoscopy procedures which are classed as “diagnostic or screening” (with or without biopsies) or as “therapeutic procedures”. The ASA does not support a differential allocation of units for these almost identical services. This proposal does not meet the criteria of simplifying the MBS nor does it reflect modern anaesthetic practice. The ASA therefore rejects Recommendation 36.

## 6.5 Recommendation 37 Upper abdomen hernia

### **Upper abdomen hernia item 20750**

- △ *Change the descriptor to include the word “wall,” and specify that the item is for hernia repair(s) to the upper abdominal wall.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for hernia repair to the upper abdominal wall, not being a service to which another item in this subgroup applies.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.6 for more information.*

### **ASA Response**

Recommendation 37 fulfils the ACC goal of minimising ambiguity and misinterpretation of the RVG, and of simplifying the RVG, therefore the ASA supports Recommendation 37.

## 6.6 Recommendation 38 Upper abdominal intraperitoneal procedures

### **Upper abdo intraperitoneal item 20790**

- △ *Change the descriptor to specify that this item covers anaesthesia for an open cholecystectomy. △ The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for procedures within the peritoneal cavity in upper abdomen including open cholecystectomy, gastrectomy, laparoscopic assisted nephrectomy or bowel shunts.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.9 for more information.*

### **ASA Response**

Recommendation 38 fulfils the ACC goal of minimising ambiguity and misinterpretation of the RVG, and of simplifying the RVG, therefore the ASA supports Recommendation 38.

## 6.7 Recommendation 39 Lower GI endoscopy

### Lower GI endoscopy item 20810

- △ *Change the descriptor to specify that this item is for diagnostic or screening procedures, and that this includes biopsies.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for diagnostic or screening lower gastrointestinal procedures including biopsies.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.7 for more information.*

### ASA Response

The ASA notes that this proposal is part of a re-organisation of anaesthesia items for endoscopy procedures with the major thrust a reduction in the base unit allocation for the majority of services. For this proposal, the re-organisation will result in two different items applying to services where currently one item (20810) covers the vast majority of all services. This clearly is not a simplification of the MBS and there is no supporting evidence provided for the change.

The ASA further notes that there is no substantial difference in the clinical management and risks involved for lower GI endoscopy procedures which are classed as “*diagnostic or screening*” (with or without biopsies) or as “*therapeutic procedures*”. This is a false and non-clinical classification from an anaesthesia perspective which unnecessarily complicates the RVG and MBS. The ASA does not support a differential allocation of units for these almost identical services. This proposal does not meet the criteria of simplifying the MBS nor does it reflect modern anaesthetic practice. The ASA therefore rejects Recommendation 39.

## 6.8 Recommendation 40 Lower abdominal intraperitoneal procedures

### **Lower abdo intraperitoneal item 20840**

- △ *Change the descriptor to specify that this item is for open procedures in the peritoneal cavity in the lower abdomen.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for all open procedures within the peritoneal cavity in lower abdomen including appendectomy, not being a service to which another item in this subgroup applies.*
- △ *Please note that this item has also been recommended for a basic unit relative value change. Please refer to Section 8.2.7 for more information.*

### **ASA Response**

Recommendation 40 fulfils the ACC goal of minimising ambiguity and misinterpretation of the RVG, and of simplifying the RVG, therefore the ASA supports Recommendation 40.

## 6.9 Recommendation 41 Anorectal procedures

### **Anorectal item 20902**

- △ *Change the descriptor to specify that the item should be used for procedures involving surgical haemorrhoidectomy, but not for the banding of haemorrhoids.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but excluding banding of haemorrhoids).*

### **ASA Response**

Anaesthesia for anorectal procedures including for the treatment of haemorrhoids should remain the same whether the procedure is banding or surgical haemorrhoidectomy, and the units value should remain 4 units. No evidence has been presented to lead to an alteration of this. This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 41 does not reduce ambiguity and misinterpretation of the RVG, and does not increase the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 41.



## 6.10 Recommendation 42 Total Hip Replacement

### **Total Hip Replacement item 21214**

- △ *Divide item 21214 into two separate items in order to more accurately reflect the differing levels of complexity involved in anaesthesia for primary and revision procedures for hip replacement. This can be done by:*
  - *Amending item 21214 to cover primary hip replacement only.*
  - *Creating a new item (2121X) to cover revision hip replacement only.*
- △ *The proposed descriptor for item 21214 is as follows:*
  - *Initiation of management of anaesthesia for primary total hip replacement.*
- △ *The proposed descriptor for new item 2121X is as follows:*
  - *Initiation of management of anaesthesia for revision total hip replacement.*
- △ *The relative value of the new item should be set at 15 basic units. Please note that item 21214 has also been recommended for a basic unit relative value change. Please refer to Section 8.2.8 for more information.*

### **ASA Response**

The ACC recommends a new item for anaesthesia for a revision hip replacement, with an allocation of 15 units. The ASA supports the concept of a higher unit allocation for this procedure. However, the service is not worth 15 units. The higher allocation of units is likely to compensate for the reduction in therapeutic and diagnostic items proposed by the ACC. This bundling of anaesthesia services is opposed by the ASA as it reduces individualised patient care, and undermines the philosophy of the RVG and the fee for service model in private healthcare in Australia.

The ASA would support an allocation of 12 units. However, as this would involve an increase in Medicare expenditure, the proposal will almost certainly have to be assessed by MSAC. Unfortunately the approach of this body to such matters in the past has been negative with the proposal likely to be rejected on spurious grounds – namely, that the service will be continue to be provided whether or not funding is increased, therefore funding will not be increased. While such an approach is at complete odds with the philosophy of the RVG, and indeed with the philosophy of Medicare itself (which is supposedly aimed at appropriate levels of funding for quality services, the level depending on the complexity of the service and the skills required to provide the service), this is the reality with which the specialty is faced.

Recommendation 42 occurs within the context of the deletion of therapeutic and diagnostic items which are essential items for the provision of safe anaesthesia in a person undergoing a revision hip operation. This recommendation therefore does not address any of the MBS Review Taskforce's four goals in particular value for the individual patients, and regarding the ACC's three goals does not simplify the RVG, or enable the RVG to support good data collection. Therefore Recommendation 42 is rejected by the ASA.

## 6.11 Recommendation 43 Gastrointestinal procedures

### ***New item for Gastrointestinal procedures***

- △ *Create a new base unit item for anaesthesia for complex and/or therapeutic lower gastrointestinal procedures. This recommendation (in conjunction with Recommendation 39) will allow the MBS to distinguish between simpler anaesthesia for lower gastrointestinal procedures (covered by item 20810) and more complex anaesthesia for lower gastrointestinal procedures (covered by this new item). This mirrors the changes made to items 20740 and 20745 for the same purpose.*
- △ *Include in the descriptor examples of the types of procedure covered by the item.*
- △ *The proposed descriptor is as follows:*
  - *Initiation of management of anaesthesia for complex and/or therapeutic lower gastrointestinal procedures, for example bowel stents, large polyp resections, or endoscopic mucosal resection ('EMR').*
- △ *The recommended relative value for this new item is four basic units.*

### **ASA Response**

As stated in response to recommendation 39, the ASA does not accept that there is a substantial difference in anaesthesia requirements, risks or patient outcomes for “diagnostic/screening” lower endoscopy anaesthesia as opposed to “therapeutic” lower endoscopy anaesthesia. The ACC report provides no supporting evidence for this recommendation.

The ASA notes that this proposal is part of a re-organisation of anaesthesia items for endoscopy procedures with the major thrust a reduction in the base unit allocation for the majority of services. For this proposal, the re-organisation will result in two different items applying to services where currently one item (20810) covers the vast majority of all services. This clearly is not a simplification of the MBS and there is no supporting evidence provided for the change. The ASA therefore rejects Recommendation 43.

## 6.12 Recommendation 44 Lens surgery

### *Lens surgery item 20142*

△ *Decrease the relative value of item 20142 from six basic units to three basic units.*

#### ASA Response

Recommendation 44 is to reduce item 20142, anaesthesia for surgery on the lens of the eye, to 3 units.

This suggestion demonstrates a failure to analyse the RVG system, and a focus on reducing rebates for commonly performed procedures, simply because they are common.

Regardless of the fact that topical anaesthesia and minimal sedation can be used to undertake this procedure, the anatomical location of the procedure needs to be considered when deciding on an appropriate unit allocation and relativities. Therefore, a comparison needs to be made between anaesthesia for cataract surgery and anaesthesia for other procedures in this anatomical location. This comparison has not been made.

The procedure involves an anatomical structure close to the airway, therefore it adds an extra degree of difficulty compared to for example, a similarly invasive procedure performed under local anaesthesia and sedation on the nerves, muscles or tendons of the lower leg. This service is covered by item 21461 and is allocated 4 units. Services of similar invasiveness to cataract surgery, performed in the head and neck area (examples include items 20100, 20120 and 20140) are all, quite appropriately, allocated 5 units. It is wrong to suggest that anaesthesia for cataract surgery is worth 2 units less than anaesthesia for other procedures on the eye, or 1 unit less than item 21461.

The ASA recognises that cataract surgery in 2017 is a different operation to what it was in 2001. As part of the ASA's review, it will be recommending that item 20142 be allocated 5 units, to bring it into line with other subgroup 1 items. This is a logical and reasonable approach.

Data from Medicare items processed for the time period July 2016 to June 2017 documented 167,572 lens surgery items, in Australia.<sup>24</sup> Disaggregated data demonstrates that that 82% of patients are aged 65 years and older. The changes proposed in Recommendation 44 will therefore impact upon over 137,000 elderly Australians requiring surgery to treat reduced vision. Rebates for this procedure would be expected to half with the proposed ACC recommendations resulting in increased out of pocket costs for nearly a quarter of a million elderly people of pensioner age over a two year period.

This recommendation does not fulfil any of the four MBS Taskforce's goals in particular does not represent value for the individual patients and with respect to the ACC's aims Recommendation 44 does not address ambiguity and misinterpretation of the RVG, complications of the RVG, or the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 44.

## 6.13 Recommendation 45 Squint repair surgery

### *Squint repair item 20147*

△ *Decrease the relative value of item 20147 from six basic units to five basic units.*

#### **ASA Response**

Recommendation 45 is to reduce item 20147, anaesthesia for squint repair to 5 units based on no evidence.

This suggestion demonstrates a failure to analyse the RVG system, and a focus on reducing rebates. In this case, regardless of any modifier items for patient age (for example only 16% of patients are aged under 4 years)<sup>24</sup>, an anaesthesia base item is just that – a base item, which covers the complexity of the initiation of management of anaesthesia. A patient’s eligibility for a modifier item is an entirely separate issue. Item 20147 has been allocated 6 units rather than 5, as it carries higher risks than other procedures performed in this anatomical location.

This recommendation does not fulfil any of the four MBS Taskforce’s goals in particular does not represent value for the individual patients and with respect to the ACC’s aims Recommendation 45 does not address ambiguity and misinterpretation of the RVG, complications of the RVG, or the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 45.

## 6.14 Recommendation 46 Breast procedures

### **Breast procedures items 20401 - 20406**

- △ Increase the relative value of item 20401 from four basic units to six basic units.
- △ Increase the relative value of item 20402 from five basic units to 10 basic units.
- △ Increase the relative value of item 20403 from five basic units to eight basic units.
- △ Increase the relative value of item 20404 from six basic units to 10 basic units.
- △ Increase the relative value of item 20405 from eight basic units to 11 basic units.
- △ Increase the relative value of item 20406 from 13 basic units to 14 basic units.

### **ASA Response**

Table 1 Summary of proposed changes to breast procedures and impact

Item	Descriptor (Initiation of management of anaesthesia for)	Proposed increase
20401	Procedures on the breast, not being a service to which another item in this subgroup applies	4 units to 6 units
20402	Reconstructive procedures on breast	5 units to 10 units
20403	Removal of breast lump or for breast segmentectomy where axillary node dissection is performed	5 units to 8 units
20404	Mastectomy	6 units to 10 units
20405	Reconstructive procedures on the breast using myocutaneous flaps	8 units to 11 units
20406	Radical or modified radical procedures on breast with internal mammary node dissection	13 units to 14 units

The ASA believes the current allocation of RVG units for all of these breast anaesthesia items reflects appropriate relativities within the RVG across the range of anaesthesia services and also reflects modern anaesthesia and surgical practice. Recommendation 46 proposes increases to all breast procedures. No evidence is provided to support the recommendation. The only basis put forward in the report is based on rebates generated per hour and the possible use of therapeutic and diagnostic items. The ASA believes the ACC approach of utilising dollars in rebates generated per hour is a wholly inappropriate method to determine appropriate unit allocations and will result in skewed unit allocations which do not reflect clinical complexity as reflected by this proposal. Further, no data on co-claiming of therapeutic and diagnostic items is provided to allow an assessment of the frequency of these services with breast services, but the ASA believes the incidence of co-claiming with therapeutic and diagnostic items to be low or very low for these items. The proposed increases in base unit allocations for these items are very large and need to be supported by strong evidence – none is provided.

This proposal demonstrates the flawed approach of attempting to compensate for the removal of items for specific services (T&D items) rather than providing benefits where the service is actually provided. Should these proposals proceed the RVG will no longer appropriately reflect relative values. Therefore the ASA rejects Recommendation 46.

## 6.15 Recommendation 47 Upper gastrointestinal endoscopy

### **Upper GI endoscopy item 20740**

△ *Decrease the relative value of item 20740 from five basic units to four basic units.*

#### **ASA Response**

The ASA opposes this 20% reduction of unit allocation from 5 to 4 units for anaesthesia for upper GI endoscopy. No evidence is provided to support the recommendation. A contemporary published study of anaesthesia for endoscopy in Australia<sup>53</sup> demonstrates that this service is associated with a high rate of patient co-morbidities and adverse outcomes and complications of anaesthesia. The comment in the ACC report that the anaesthesia service is “often provided by non-anaesthetists” is completely ignorant of the facts and does not reflect modern anaesthetic practice in Australia where the vast majority of services are provided by specialist anaesthetists.

The reduction of base units from 5 to 4 is not consistent with the relativities of the RVG. Upper GI endoscopy involves a shared airway and the unit allocation of 5 is consistent with other anaesthesia services within the RVG with a shared airway which receive a 5 or 6 unit allocation. The ASA believes that the current 5 unit allocation is appropriate.

The ASA does not support the artificial differentiation of upper GI endoscopy anaesthesia into diagnostic and therapeutic. For the anaesthesia service there is no practical difference in the complexity and risk of the anaesthesia and therefore is no requirement for differing unit allocations.

The impact of this reduction in unit allocation (and therefore in patient benefits), particularly when coupled with the targeted reduction in benefits for those patients over 70 years of age will be very significant. The ASA estimates that at least 95% of all upper GI endoscopy patients will receive lower Medicare benefits, with a large number of patients’ benefits reduced by 33%. Coupled with the newly restrictive consultation items this could lead to 50% reductions in total patient benefits.

Clearly such large reductions in patient benefits will produce an impact on consumers. Noting that the vast majority of patients undergoing upper GI endoscopy procedures currently are faced with no requirement for gap payments (ie \$0 out-of-pocket), the ASA is very concerned that there will be the emergence of significant gaps to cover the very large reductions in patient benefits. This could lead to a reduction in accessibility of the service with patients reconsidering the need for such services as cancer screening and follow-up procedures. The ASA rejects Recommendation 47.

## 6.16 Recommendation 48 Upper gastrointestinal endoscopy

### *Upper gastrointestinal endoscopy item 20745*

△ *Decrease the relative value of item 20745 from six basic units to five basic units.*

#### **ASA Response**

The ASA does support the relativity of this service compared to upper GI endoscopy, but believes the latter should remain with a unit allocation of 5 units for the reasons detailed in the response to recommendation 47 and therefore the former should remain with a unit allocation of 6 units.

No evidence is provided to support the recommendation. Therefore the ASA rejects Recommendation 48.

## 6.17 Recommendation 49 Upper abdomen hernia

### ***Upper abdomen hernia item 20750***

△ *Increase the relative value of item 20750 from four basic units to six basic units.*

#### **ASA Response**

The ASA rejects this recommendation



## 6.18 Recommendation 50 Lower gastrointestinal endoscopy

### **Lower gastrointestinal endoscopy item 20810**

△ *Decrease the relative value of item 20810 from four basic units to three basic units.*

#### **ASA Response**

The ASA opposes this 25% reduction of unit allocation from 4 to 3 units for anaesthesia for lower GI endoscopy. No evidence is provided to support the recommendation. A contemporary published study of anaesthesia for endoscopy in Australia<sup>53</sup> demonstrates that this service is associated with a high rate of patient co-morbidities and adverse outcomes and complications of anaesthesia. The comment in the ACC report that the anaesthesia service is “often provided by non-anaesthetists” is completely ignorant of the facts and does not reflect modern anaesthetic practice in Australia where the vast majority of services are provided by specialist anaesthetists.

The reduction of base units from 4 to 3 is not consistent with the relativities of the RVG. Lower GI endoscopy is an internal procedure which is provided under anaesthesia in modern Australian practice. The current unit allocation of 4 is consistent with other anaesthesia services within the RVG. The ASA believes that the current 4 unit allocation is appropriate.

The ASA does not support the artificial differentiation of lower GI endoscopy anaesthesia into diagnostic and therapeutic. For the anaesthesia service there is no practical difference in the complexity and risk of the anaesthesia and there is no requirement for differing unit allocations.

The impact of this reduction in unit allocation (and therefore in patient benefits), particularly when coupled with the targeted reduction in benefits for those patients over 70 years of age will be very significant. The ASA estimates that at least 95% of all lower GI endoscopy patients will receive lower Medicare benefits, with a large number of patients’ benefits reduced by 38%. Coupled with the newly restrictive consultation items this could lead greater than 50% reductions in patient benefits.

Clearly such large reductions in patient benefits will produce an impact on consumers. Noting that the vast majority of patients undergoing lower GI endoscopy procedures currently are faced with no requirement for gap payments (ie \$0 out-of-pocket), the ASA is very concerned that there will be the emergence of significant gaps to cover the very large reductions in patient benefits. This could lead to a reduction in accessibility of the service with patients reconsidering the need for such services as cancer screening and follow-up procedures. Therefore the ASA rejects Recommendation 50.

## 6.19 Recommendation 51 Total Hip Replacement

### **Total Hip Replacement item 21214**

△ *Increase the relative value for revised item 21214 for primary hip replacement from 10 basic units to 14 basic units.*

### **ASA Response**

The ACC recommends increasing the relative value for primary hip replacement. The ASA supports the concept of a higher unit allocation for this procedure. However, the service is not worth 14 units. The higher allocation of units is likely to compensate for the reduction in therapeutic and diagnostic items proposed by the ACC. This bundling of anaesthesia services is opposed by the ASA as it reduces individualised patient care, and undermines the philosophy of the RVG and the fee for service model in private healthcare in Australia. Item 21214 should be allocated 10 units as this is its appropriate relative value, and any therapeutic and diagnostic items involved must be preserved.

Recommendation 51 occurs within the context of the deletion of therapeutic and diagnostic items which are essential items for the provision of safe anaesthesia in a subgroup of people undergoing a primary hip replacement operation. This recommendation therefore does not address any of the MBS Review Taskforce's four goals in particular value for the individual patients, and regarding the ACC's three goals does not simplify the RVG, or enable the RVG to support good data collection. Therefore Recommendation 51 is rejected by the ASA.

## 6.20 Recommendation 52 Multiple basic unit items - increases

- △ Increase the relative value for item 20174 from nine basic units to 10 basic units.
- △ Increase the relative value for item 20176 from 10 basic units to 11 basic units.
- △ Increase the relative value for item 20192 from 10 basic units to 13 basic units.
- △ Increase the relative value for item 20210 from 15 basic units to 21 basic units.
- Increase the relative value for item 20212 from five basic units to eight basic units.
- Increase the relative value for item 20214 from nine basic units to 13 basic units.
- Increase the relative value for item 20216 from 20 basic units to 26 basic units.
- Increase the relative value for item 20220 from 10 basic units to 13 basic units.
- Increase the relative value for item 20225 from 12 basic units to 13 basic units.
- Increase the relative value for item 20230 from 12 basic units to 17 basic units.
- △ Increase the relative value for item 20305 from 15 basic units to 17 basic units.
- △ Increase the relative value for item 20320 from six basic units to eight basic units.
- △ Increase the relative value for item 20321 from 10 basic units to 12 basic units.
- △ Increase the relative value for item 20350 from 10 basic units to 14 basic units.
- △ Increase the relative value for item 20355 from 12 basic units to 18 basic units.
- △ Increase the relative value for item 20450 from five basic units to six basic units.
- △ Increase the relative value for item 20452 from six basic units to eight basic units.
- △ Increase the relative value for item 20472 from 10 basic units to 15 basic units.
- △ Increase the relative value for item 20474 from 13 basic units to 17 basic units.
- △ Increase the relative value for item 20475 from 10 basic units to 16 basic units.
- △ Increase the relative value for item 20500 from 15 basic units to 28 basic units.
- △ Increase the relative value for item 20526 from 10 basic units to 18 basic units.
- △ Increase the relative value for item 20528 from eight basic units to 12 basic units.
- △ Increase the relative value for item 20540 from 13 basic units to 23 basic units.
- △ Increase the relative value for item 20542 from 15 basic units to 27 basic units.
- △ Increase the relative value for item 20546 from 15 basic units to 27 basic units.
- △ Increase the relative value for item 20548 from 15 basic units to 26 basic units.
- △ Increase the relative value for item 20560 from 20 basic units to 36 basic units.
- △ Increase the relative value for item 20600 from 10 basic units to 14 basic units.

- △ Increase the relative value for item 20604 from 13 basic units to 18 basic units.*
- △ Increase the relative value for item 20620 from 10 basic units to 12 basic units.*
- △ Increase the relative value for item 20630 from eight basic units to 10 basic units.*
- △ Increase the relative value for item 20670 from 13 basic units to 19 basic units.*
- △ Increase the relative value for item 20680 from three basic units to four basic units.*
- △ Increase the relative value for item 20704 from 10 basic units to 11 basic units.*
- Increase the relative value for item 20752 from six basic units to seven basic units.*
- Increase the relative value for item 20756 from nine basic units to 12 basic units.*
- Increase the relative value for item 20770 from 15 basic units to 21 basic units.*
- Increase the relative value for item 20790 from eight basic units to nine basic units.*
- Increase the relative value for item 20791 from 10 basic units to 12 basic units.*
- Increase the relative value for item 20792 from 13 basic units to 23 basic units.*
- Increase the relative value for item 20793 from 15 basic units to 27 basic units.*
- Increase the relative value for item 20794 from 12 basic units to 22 basic units.*
- Increase the relative value for item 20798 from 10 basic units to 17 basic units.*
- △ Increase the relative value for item 20800 from three basic units to four basic units.*
- △ Increase the relative value for item 20802 from five basic units to eight basic units.*
- △ Increase the relative value for item 20804 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 20830 from four basic units to six basic units.*
- △ Increase the relative value for item 20832 from six basic units to seven basic units.*
- △ Increase the relative value for item 20840 from six basic units to seven basic units.*
- △ Increase the relative value for item 20841 from eight basic units to 12 basic units.*
- △ Increase the relative value for item 20844 from 10 basic units to 16 basic units.*
- △ Increase the relative value for item 20845 from 10 basic units to 17 basic units.*
- △ Increase the relative value for item 20846 from 10 basic units to 12 basic units.*
- △ Increase the relative value for item 20847 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 20848 from 10 basic units to 19 basic units.*
- △ Increase the relative value for item 20848 from 12 basic units to 13 basic units.*
- △ Increase the relative value for item 20855 from 15 basic units to 21 basic units.*
- △ Increase the relative value for item 20863 from 10 basic units to 16 basic units.*

- △ Increase the relative value for item 20864 from 10 basic units to 20 basic units.*
- △ Increase the relative value for item 20866 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 20867 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 20868 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 20880 from 15 basic units to 19 basic units.*
- △ Increase the relative value for item 20904 from seven basic units to eight basic units.*
- △ Increase the relative value for item 20905 from 10 basic units to 13 basic units.*
- △ Increase the relative value for item 20942 from five basic units to seven basic units.*
- △ Increase the relative value for item 20944 from six basic units to nine basic units.*
- △ Increase the relative value for item 20946 from eight basic units to 10 basic units.*
- Increase the relative value for item 20958 from five basic units to six basic units.*
- Increase the relative value for item 20960 from seven basic units to nine basic units.*
- Increase the relative value for item 21120 from six basic units to seven basic units.*
- Increase the relative value for item 21140 from 15 basic units to 21 basic units.*
- Increase the relative value for item 21150 from 10 basic units to 16 basic units.*
- Increase the relative value for item 21155 from 10 basic units to 16 basic units.*
- Increase the relative value for item 21170 from eight basic units to ten basic units.*
- Increase the relative value for item 21195 from three basic units to four basic units.*
- Increase the relative value for item 21202 from four basic units to six basic units.*
- △ Increase the relative value for item 21210 from six basic units to nine basic units.*
- △ Increase the relative value for item 21212 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 21216 from 14 basic units to 20 basic units.*
- △ Increase the relative value for item 21230 from six basic units to nine basic units.*
- △ Increase the relative value for item 21232 from five basic units to eight basic units.*
- △ Increase the relative value for item 21234 from eight basic units to 13 basic units.*
- △ Increase the relative value for item 21260 from four basic units to five basic units.*
- △ Increase the relative value for item 21270 from eight basic units to nine basic units.*
- △ Increase the relative value for item 21274 from six basic units to nine basic units.*
- △ Increase the relative value for item 21275 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 21360 from five basic units to seven basic units.*

- △ Increase the relative value for item 21392 from four basic units to five basic units.*
- △ Increase the relative value for item 21400 from four basic units to five basic units.*
- △ Increase the relative value for item 21402 from seven basic units to 12 basic units.*
- △ Increase the relative value for item 21403 from 10 basic units to 16 basic units.*
- △ Increase the relative value for item 21440 from eight basic units to nine basic units.*
- △ Increase the relative value for item 21445 from 10 basic units to 16 basic units.*
- △ Increase the relative value for item 21464 from four basic units to five basic units.*
- △ Increase the relative value for item 21472 from five basic units to six basic units.*
- △ Increase the relative value for item 21480 from four basic units to five basic units.*
- △ Increase the relative value for item 21486 from seven basic units to eight basic units.*
- △ Increase the relative value for item 21500 from eight basic units to nine basic units.*
- △ Increase the relative value for item 21520 from four basic units to five basic units.*
- △ Increase the relative value for item 21535 from 10 basic units to 14 basic units.*
- △ Increase the relative value for item 21610 from five basic units to six basic units.*
- Increase the relative value for item 21622 from five basic units to eight basic units.*
- Increase the relative value for item 21630 from five basic units to six basic units.*
- Increase the relative value for item 21632 from six basic units to 10 basic units.*
- Increase the relative value for item 21638 from 10 basic units to 13 basic units.*
- Increase the relative value for item 21650 from eight basic units to nine basic units.*
- Increase the relative value for item 21656 from 10 basic units to 15 basic units.*
- Increase the relative value for item 21700 from three basic units to four basic units.*
- Increase the relative value for item 21710 from four basic units to five basic units.*
- Increase the relative value for item 21756 from six basic units to seven basic units.*
- △ Increase the relative value for item 21760 from seven basic units to eight basic units.*
- △ Increase the relative value for item 21785 from 10 basic units to 13 basic units.*
- △ Increase the relative value for item 21830 from four basic units to five basic units.*
- △ Increase the relative value for item 21834 from four basic units to five basic units.*
- △ Increase the relative value for item 21865 from 10 basic units to 12 basic units.*
- △ Increase the relative value for item 21870 from 15 basic units to 17 basic units.*

- Δ Increase the relative value for item 21882 from 11 basic units to 13 basic units.*
- Δ Increase the relative value for item 21916 from five basic units to six basic units.*
- Δ Increase the relative value for item 21941 from seven basic units to eight basic units.*
- Δ Increase the relative value for item 21942 from 10 basic units to 14 basic units.*
- Δ Increase the relative value for item 21990 from three basic units to five basic units.*

#### **ASA Response**

Recommendation 52 proposes to increase the relativity of 123 items. This has not been done to address the relativity of these services in 2017 but rather to compensate for the deletion of therapeutic and diagnostic items. This is a philosophical shift and moves the RVG away from patient centred care and individualised services for patients. It moves anaesthesia services closer towards an hourly rate model which is retrograde and detrimental to patient care, and undermines the independence of anaesthesia as a specialty. The base unit for caesarean section is not included in this section thereby further disadvantaging approximately 36,000 pregnant women undergoing caesarean section each year who already face the additional proposed loss of the therapeutic and diagnostic items.

This recommendation does not fulfil any of the four MBS Taskforce's goals, in particular does not represent value for the individual patients and with respect to the ACC's aims Recommendation 52 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. This recommendation represents a fundamental negative shift in the philosophy of the RVG. The ASA therefore rejects Recommendation 52.



## 6.21 Recommendation 53 Multiple basic unit items - decreases

- △ *Decrease the relative value for item 20104 from four basic units to two basic units.*
- △ *Decrease the relative value for item 20120 from five basic units to four basic units.*
- △ *Decrease the relative value for item 20140 from five basic units to three basic units.*
- △ *Decrease the relative value for item 20144 from eight basic units to six basic units.*
  - △ *Decrease the relative value for item 20145 from eight basic units to six basic units.*
  - △ *Decrease the relative value for item 20160 from six basic units to five basic units.*
  - △ *Decrease the relative value for item 20170 from six basic units to five basic units.*
  - △ *Decrease the relative value for item 20410 from five basic units to three basic units.*
  - △ *Decrease the relative value for item 20690 from five basic units to four basic units.*
  - △ *Decrease the relative value for item 20910 from four basic units to three basic units.*
  - △ *Decrease the relative value for item 20914 from seven basic units to six basic units.*
- △ *Decrease the relative value for item 20943 from four basic units to three basic units.*
- △ *Decrease the relative value for item 20953 from five basic units to four basic units.*
- △ *Decrease the relative value for item 21114 from five basic units to four basic units.*
- △ *Decrease the relative value for item 21912 from five basic units to three basic units.*
- △ *Decrease the relative value for item 21922 from seven basic units to six basic units.*
- △ *Decrease the relative value for item 21927 from five basic units to three basic units.*
- △ *Decrease the relative value for item 21936 from six basic units to four basic units.*
- △ *Decrease the relative value for item 21943 from five basic units to four basic units.*
- △ *Decrease the relative value for item 21945 from five basic units to three basic units.*
- △ *Decrease the relative value for item 21952 from 10 basic units to four basic units.*
- △ *Decrease the relative value for item 21955 from five basic units to three basic units.*
- △ *Decrease the relative value for item 22900 from six basic units to four basic units.*
- △ *Decrease the relative value for item 22905 from six basic units to four basic units.*



Table 2 Summary of proposed changes and impacts

Item	Descriptor (An Initiation of management of anaesthesia for)	Proposed reduction
20104	Electroconvulsive therapy	4 units to 2 units
<p>This proposal is deeply flawed. ECT involves an extremely noxious stimulus to the patient, and the physiological stress response involved has been shown to carry significant risks. The procedure also involves the administration of a muscle relaxant, to decrease the significant and potentially dangerous tonic-clonic movements which are innate to the procedure. ECT patients have, by definition, a significant mental illness, which in and of itself increases clinical risk. Additionally, there is also a higher incidence of smoking, alcohol use, and use of both prescription and illicit drug use in this population. The proposal is based on the fact that ECT is almost always a procedure of short duration, which can increase the notional average rebate per hour. However, if the ACC wishes to pursue a decrease in the funding of anaesthesia services, it is taking the wrong approach here. The anaesthesia services are provided overwhelmingly at no out-of-pocket expenses to patients. The result of the ACC's proposal is that the provision of these services will be endangered, to the detriment of this very vulnerable patient group. The proposal must be rejected.</p>		
20120	Procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this subgroup applies	5 units to 4 units
<p>This proposal demonstrates the ACC's failure to appreciate relativities. These procedures involve surgery in proximity to the airway therefore this proposal must be rejected.</p>		
20140	Procedures on eye, not being a service to which another item in this group applies	5 units to 3 units
<p>This proposal demonstrates the ACC's failure to appreciate relativities. These procedures involve surgery in proximity to the airway therefore this proposal must be rejected.</p>		
20144	Corneal transplant	8 units to 6 units
<p>Based on the nature of the procedures in 2017 vs 2001 when the items were introduced, the ASA supports this reduction</p>		
20145	Vitrectomy	8 units to 6 units
<p>Based on the nature of the procedures in 2017, vs 2001 when the items were introduced, the ASA supports this reduction</p>		

Item	Descriptor (An Initiation of management of anaesthesia for)	Proposed reduction
20160	Procedures on nose or accessory sinuses, not being a service to which another item in this subgroup applies	6 units to 5 units
6 units is appropriate for invasive procedures on the nose, or on the accessory sinuses. This proposal should be rejected		
20170	Intraoral procedures, including biopsy, not being a service to which another item in this subgroup applies	6 units to 5 units
This anaesthesia service, involving a shared airway, is appropriately allocated 6 units. This proposal should be rejected.		
20410	Electrical conversion of arrhythmias	5 units to 3 units
This proposal is entirely inappropriate. The service is of higher relative value than the various other 3-unit anaesthesia services. A logical unit allocation would be 4 units which is an appropriate relative value being the same as anaesthesia for ECT.		
20690	Percutaneous spinal procedures, not being a service to which another item in this subgroup applies	5 units to 4 units
This procedure typically involves having the patient in a prone position. This adds a degree of complexity to the anaesthesia service, compared to other percutaneous procedures. Other items covering services for which the patient is placed in the prone position also take this into account. The relative value of 5 units is correct, and the proposal should be rejected.		
20910	Transurethral procedures (including urethrocystoscopy), not being a service to which another item in this subgroup applies	4 units to 3 units
The existing unit allocation for this procedure is appropriate. It is a more invasive procedure than others performed in the same anatomical region, for which anaesthesia services are currently allocated 3 units. The proposal again appears to be aimed purely at cost cutting and must be rejected.		
20914	Transurethral resection of prostate	7 units to 6 units
The ASA can see no logical reason for this proposal. It is a significantly more complex procedure than anaesthesia for transurethral resection of bladder tumours (5 units) and the existing relativity is correct. This proposal must be rejected.		
20943	Transvaginal assisted reproductive services	4 units to 3 units
There is no logical reason for this proposal. It is clearly aimed solely at cost cutting, and again demonstrates the ACC's failure to appreciate relativities. The current allocation of 4 units matches that for procedures of similar complexity performed in the same anatomical area (item 20940 being a classic example). The proposal should be rejected.		
20953	Endometrial ablation or resection in association with hysteroscopy	5 units to 4 units
Given the modern surgical techniques are utilised for this procedure compared to when the item was introduced in 2001, a 4 unit allocation is appropriate.		

Item	Descriptor (An Initiation of management of anaesthesia for)	Proposed reduction
21114	Percutaneous bone marrow biopsy of the posterior iliac crest	5 units to 4 units
<p>The relativity of the existing unit allocation is correct, as the procedure is often performed with the patient in the prone position. It is more invasive and uncomfortable than procedures performed in the same anatomical region but which are allocated 4 units. The proposed reduction should be rejected.</p>		
21912	Injection procedure for discography: lumbar or thoracic	5 units to 3 units
<p>There is no logical reason for this reduction. Anaesthesia services for the equivalent procedure of lumbar or thoracic myelography are allocated 5 units. Again, the prone position issue arises. The proposal should be rejected.</p>		
21922	Computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning	7 units to 6 units
<p>This is an appropriate reduction.</p>		
21927	Barium enema or other opaque study of the small bowel	5 units to 3 units
<p>The ASA believes this service should be allocated 4 units, as per other anorectal procedures. It is worth noting that there were only 2 claims for the service for the financial year 2015-16. The item could be safely deleted, and claims directed to item 20902 (4 units)</p>		
21936	Heart, 2 dimensional real time transoesophageal examination	6 units to 4 units
<p>The ASA believes this service has the same relative value as item 20740. It should therefore be allocated 5 units</p>		
21943	Central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure	5 units to 4 units
<p>As this procedure involves the surgeon working close to the airway, the current unit allocation is appropriate, as per items such as 20100. The proposal should be rejected</p>		
21945	Lumbar puncture, cisternal puncture, or epidural injection	5 units to 3 units
<p>Anaesthesia is only required for these procedures if there are difficulties predicted – for example, in children or in intellectually disabled patients. These groups will be the ones most disadvantaged by this cut. Patient positioning is again an issue. The proposal should be rejected</p>		
21952	Muscle biopsy for malignant hyperpyrexia	10 units to 4 units
<p>The modern surgical and anaesthesia approach to this service has made it much less complex justifying a reduction to 4 units</p>		
21955	Electroencephalography	5 units to 3 units
<p>The ACC has overlooked MBS items for similar procedures – a 5 unit allocation is perfectly appropriate for a procedure performed in this anatomical location. The proposal should be rejected.</p>		

Item	Descriptor (An Initiation of management of anaesthesia for)	Proposed reduction
22900	Extraction of tooth or teeth with or without incision of soft tissue or removal of bone	6 units to 4 units
22905	Restorative dental work	6 units to 4 units

This represents another example of failure to appreciate the relative values of similar services. It would appear to be motivated solely by the fact that these claims are common. When these two items are combined, they represent the fourth-most common source of anaesthesia claims. The anatomical location of the procedure would usually attract 5 units, and the fact that it involves a shared airway means that the service is worth 6 units. Many of these services are provided for children, meaning that a vulnerable group has been targeted. The proposal should be rejected.

### ASA Response

Recommendation 53 proposes to decrease the relativity of 24 items. These items are not discussed individually or even in groups of similar items which is illogical and inconsistent.

This recommendation does not fulfil any of the four MBS Taskforce's goals in particular does not represent value for the individual patients and with respect to the ACC's aims Recommendation 53 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. This recommendation represents a fundamental negative shift in the philosophy of the RVG. The ASA therefore rejects Recommendation 53.

## 6.22 Recommendation 54 Radical nasal/sinus surgery

### **Radical nasal/sinus surgery item 20162**

△ Delete item 20162.

#### **ASA Response**

Recommendation 54 proposed deletion of Item 20162, anaesthesia for radical procedures on the nose/accessory sinuses. No evidence is presented to justify this deletion therefore this is inappropriate. If there is concern or uncertainty regarding the clinical nature of services covered by this item, they should be elucidated, rather than just deleting the item.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 54 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. This recommendation represents a fundamental negative shift in the philosophy of the RVG. The ASA therefore rejects Recommendation 54.

## 6.23 Recommendation 55 Diagnostic laparoscopy

### **Diagnostic laparoscopy items 20705, 20805**

△ Delete items 20705 and 20805.

#### **ASA Response**

Recommendation 55 proposes that items 20705 and 20805 for anaesthesia diagnostic laparoscopic procedures be deleted. The ASA agrees that these items are no longer necessary.

This recommendation does fulfil the MBS Taskforce's goals of modernising the RVG and aligning it with contemporary practice. The ASA therefore accepts Recommendation 55.

## 6.24 Recommendation 56 TURBT

### **TURBT item 20912**

△ Delete item 20912.

#### **ASA Response**

Recommendation 56 proposes that item 20912 for anaesthesia for transurethral resection of bladder tumours (TURBT) is deleted. TURBT is a more complex procedure than diagnostic cystoscopy with consideration needing to be given to post-operative pain management. Merging this item into item 20910 also conflicts with the aim of the ACC to ensure accurate data collection.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 56 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 56.

## 6.25 Recommendation 57 Fluoroscopy

### **Fluoroscopy item 21926**

*Delete item 21926.*

#### **ASA Response**

Recommendation 57 is to delete anaesthesia for fluoroscopy. The ACC has presented no evidence to support its assertion that anaesthesia for fluoroscopies is obsolete. Data from Medicare items processed for the time period July 2016 to June 2017 documented 5,071 items for anaesthesia for fluoroscopy in Australia.<sup>24</sup> Disaggregated data demonstrates that this service is used in all age ranges and in both genders suggesting that it is a service that is required in the Australian community.

This recommendation does not fulfil any of the four MBS Taskforce's goals and regarding the ACC's aims Recommendation 57 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 57.

## 6.26 Recommendation 58 Radiological or other diagnostic or therapeutic procedures

### **Delete items 21956, 21997**

*△ Delete items 21965 and 21997.*

#### **ASA Response**

Recommendation 58 proposes deletion of items related to radiological or other diagnostic or therapeutic procedures. The ACC recommends deletion of items 21965 and 21997 on the basis that they require MCRP approval (which is often not forthcoming) and that they are obsolete.

The items are definitely not obsolete. The mere fact that items are rarely claimed does not mean that they are not worthy of retention. Anaesthesia as a therapeutic procedure may be required, by way of example, for a patient in status epilepticus. It is also possible that anaesthesia may be required for a paediatric patient, or intellectually disabled patient, for a procedure which would not normally attract an anaesthesia benefit, where the term "(Anaes)" does not appear after the procedural item descriptor. The issue of MCRP approval is irrelevant to the question of whether or not an item represents a service which is of value to patients.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 58 does not address ambiguity and misinterpretation of the RVG, or the ability of the RVG to support good data collection. The ASA therefore rejects Recommendation 58.

## 6.27 Recommendation 59 Multiple items

*△ No change to the items in Table 58.*

#### **ASA Response**

The ASA supports making no changes to the RVG without appropriate consultation and an evidenced based approach to reviewing item numbers. Therefore the ASA supports Recommendation 59 to make no changes to items in Table 58.

## 7. Other items

### 7.1 Recommendation 60 Multiple items

△ *No change for the items in Table 59.*

#### ASA Response

The ASA supports making no changes to the RVG without appropriate consultation and an evidenced based approach to reviewing item numbers. Therefore the ASA supports Recommendation 59 to make no changes to items in Table 58.

### 7.2 Recommendation 61 Multiple items

△ *No change for the items in Table 61*

#### ASA Response

The ASA supports making no changes to the RVG without appropriate consultation and an evidenced based approach to reviewing item numbers. Therefore the ASA supports Recommendation 59 to make no changes to items in Table 58.

### 7.3 Recommendation 62 Multiple items

△ *No change to items 25200 and 25205.*

#### ASA Response

The ASA supports making no changes to the RVG without appropriate consultation and an evidenced based approach to reviewing item numbers. Therefore the ASA supports Recommendation 59 to make no changes to items in Table 58.

## 8. Non-item recommendations

### 8.1 Recommendation 63 RVG dollar value and indexation

*The Committee recommended that a review be undertaken into:*

- △ *The dollar value of the MBS RVG basic unit (currently \$19.80), assigned for the purpose of calculating schedule fees for the anaesthesia MBS RVG.*
- △ *Appropriate indexation for MBS items.*

#### ASA Response

The ACC believes a review of the MBS Fee for the RVG unit (\$19.80) be undertaken and that there is appropriate indexation for MBS items. The MBS Fees for anaesthesia represent a gross undervaluation of the services of specialist anaesthetists. This is amply demonstrated by the fact that anaesthesia expenditure via the Medicare system is less than a quarter than that spent on surgical/procedural services. By way of comparison, the services of surgical assistants (where needed) are by definition valued at 20% of the MBS Fee for the procedural service. The ASA supports Recommendation 63.

### 8.2 Recommendation 64 Start and finish times

#### *Start and finish times*

- △ *Mandate the recording of start and end times for all MBS procedures.*
- △ *The Committee has forwarded this recommendation to the Principles and Rules Committee to consider whether it should be applied to other craft groups.*

#### ASA Response

Start and end times are not recorded by any other discipline and is therefore an inconsistent recommendation compared with other Clinical Committee reports. No evidence is presented for the benefit of including this additional data. Regarding accuracy, times on hospital clocks are widely variable, and as such these times would be impossible to verify.<sup>31</sup> Patients would be largely amnesic for the duration of their procedure so are unaware of start and finish times and knowing this information provides nothing to the consumer, other than to tell them how long their procedure was. This recommendation places an unnecessarily high administrative burden on anaesthetists, and on no other specialists. The Principles and Rules Committee needs to be consistent with all of the specialities therefore if this is introduced for anaesthesia it must be introduced for all specialities.

This recommendation does not fulfil any of the four MBS Taskforce's goals and with respect to the ACC's aims Recommendation 64 increases complicates the RVG, and has not effect on the RVG to support good data collection. The ASA therefore rejects Recommendation 64.



### 8.3 Recommendation 65 Written information to patients

#### **Written information to patients**

△ *Require all anaesthesia providers to inform the patient in writing of the item number, the schedule fee, the start and finish time, and the full item descriptor for all items billed.*

△ *The Committee referred this recommendation to the Principles and Rules Committee.*

#### **ASA Response**

The ACC has not provided any evidence for the benefit of this. Most anaesthesia services incur no out of pocket costs for patients and most patients do not see their account as their private health funds reconcile it for them. Patients who may pay an out of pocket cost should receive informed financial consent and the specific details of the start and finish times being recorded on their account are not relevant or helpful in any way. Consumers from a non-health-profession background cannot be expected to understand the MBS system well, and the provision of reams of extra paperwork would only serve to confuse and possibly upset them. This proposal is likely to add considerable administrative burdens to anaesthetists and therefore costs, which will ultimately be borne by the consumer. The ASA rejects this recommendation.

### 8.4 Recommendation 66 Fees complaints body

#### **Fees complaints body**

△ *Introduce an independent complaints body to address patient complaints regarding anaesthesia items and fees.*

#### **ASA Response**

The ASA has no particular issue with the setting up of an independent body to receive patient complaints, but would suggest that bodies such as Medical Boards and Ombudsman's offices already serve this purpose. Patient education in this regard may be all that is needed. There is no evidence that there are major consumer concerns with anaesthesia fees or items and the available data demonstrates that the majority of patients have no out-of-pocket expenses for anaesthesia services, and where there is a gap payment, it is considerably lower than for most other specialties. If a specific body was to be set up, it would seem consistent that every specialty would require a similar complaints body. The ASA is not aware of any such proposals for other specialties.

The ASA also takes exception to the assertion that it is not an "adequate point of contact" for patients with complaints. The ASA receives complaints and queries from patients on a frequent basis, and always handles them appropriately, with a focus on what is best for the patient. The patients are invariably wholly satisfied with our assistance.

## 8.5 Recommendation 67 Committee to provide advice to Department of Health

- △ *Establish a committee to provide ongoing advice to the Department of Health on anaesthesia MBS items.*
- △ *Continue the review of MBS items in response to data.*

### ASA Response

The ASA agrees that ongoing review is important, but it is essential that the ASA, as the key stakeholder, and with the extensive knowledge and experience required, is not deliberately excluded from this process, if the process is to be seen to have any legitimacy. The ACC has demonstrated that, under its current make-up, it is incapable of performing this task on its own.

The ASA accepts that it exists to support its members. However, this is no reason to exclude it from the process. Any suggestion that the ASA would utilise this specific ongoing review process purely to advance its members' interests, is offensive. The ASA's committee members are, first and foremost, medical practitioners, whose entire professional lives have been devoted to best possible patient care, since their time as medical students. Our office bearers are quite capable of distinguishing between the needs of our patients, the interests of Government, and the interests of our speciality. The ASA notes, based on feedback from anaesthetists in various parts of the country, that the opaque process of appointing people to the ACC has chosen a group with known anti-RVG and anti-fee-for-service views. People have a perfectly valid right to hold these views. However, in any meaningful review process, input from a range of stakeholders, should be fully involved at all stages. Any future review committee members should be drawn from the ASA and ANZCA and anaesthesia academia, and should be there as an ex-officio capacity (E.g. College and Society past presidents). They should be compelled to provide well researched evidence for alterations to the RVG, without necessarily going through the adversarial MSAC process.

There is a serious risk to the Department in having a standing committee of persons drawn from some opaque process who could easily be influenced by external agencies to make changes.

## 9. Conclusion

In conducting a non-collaborative review of the 528 MBS items pertaining to anaesthesia, that is devoid of crucial evidence and that ignores best-practice, the ACC have put at risk affordability and access to healthcare for vulnerable Australians. To implement the majority of these recommendations without an evidence base, and appropriate consultation with consumers and the speciality, represents a gross failing of the governance at all levels.

For the reasons outlined in this response document, the current ACC report with its 67 Recommendations is unacceptable. The ASA is committed to reducing ambiguity and misinterpretation of the RVG, simplifying the RVG, and enabling the RVG to support good data collection. The ASA agrees with 19 of the Recommendations outlined in Appendix 1.

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## 11.APPENDIX 1

The following **19 Recommendations** are the ones that **ASA agrees** with.

### Therapeutic and diagnostic item recommendations

Item	What it does	ACC recommendation	ASA Position
18216, 18219, 18226, 18227	These items are for epidural injections of anaesthesia substances.	12. Change the descriptor.	<b>AGREE</b>
22020	This item is for insertion of a catheter into a central vein.	15. Increase the value of the item to align with an item that covers the same procedure, performed by different clinicians.	<b>AGREE</b>
22051	This item is for inserting a device through the throat that monitors the structure and function of the chambers of the heart.	17. Introduce a rule dictating the minimum credentials required to perform this procedure.	<b>AGREE</b>

Item	What it does	ACC recommendation	ASA Position
22001	This item is for collecting the patient's own blood and re-injecting it later, during and after surgery, including when the patient is under anaesthesia.	18. Delete this item.	<b>AGREE</b>
22018	This item is for the monitoring of the function of the lung and/or ventilator (breathing machine). The item requires that more than one arterial blood sample is taken, and that adjustments to breathing (usually via adjusting a ventilator) then take place.	22. Delete the item.	<b>AGREE</b>
22070	This item is for cardioplegia – the delivery of fluid to the heart in order to slow and then stop the heart for some cardiac operations. The solution is delivered via tubes inserted into blood vessels by the surgeon.	25. Delete the item.	<b>AGREE</b>
18233	This item is for an epidural blood patch.	28. No change.	<b>AGREE</b>



### Modifying item recommendations

Item	What it does	ACC recommendation	ASA Position
New item [252XX]	This item does not currently exist.	31. Create a new item to rebate an assisting anaesthetist in the administration of item 18233 for epidural blood patch.	<b>AGREE</b>
25005, 25010, 25020, 25025, 25030, 25050	These items provide an extra rebate for anaesthesia services performed on patients suffering from a disease or in an emergency situation that makes the anaesthesia more complex to perform.	32. No change	<b>AGREE</b>

### Base item recommendations

Item	What it does	Committee recommendation	ASA Position
20706	This item is for anaesthesia services performed during laparoscopic procedures in the upper abdomen.	34. Change the descriptor.	<b>AGREE</b>

Item	What it does	Committee recommendation	ASA Position
20750	This item is for anaesthesia services performed during procedures involving hernia repairs in the upper abdomen.	37. Change the descriptor.	<b>AGREE</b>
20790	This item is for anaesthesia services performed during procedures in the peritoneal cavity in the upper abdomen.	38. Change the descriptor.	<b>AGREE</b>
20840	This item is for anaesthesia services performed during procedures in the peritoneal cavity in the lower abdomen.	40. Change the descriptor.	<b>AGREE</b>
20705, 20805	These items are for anaesthesia services performed during diagnostic laparoscopic procedures.	55. Delete the items.	<b>AGREE</b>

20124, 20148, 20164, 20100, 20146, 20190, 20102, 20143, 20222, 20172, 20300, 20352, 20330, 20400, 20440, 20420, 20470, 20522, 20524, 20520, 20632, 20634, 20622, 20700, 20702, 20703, 20730, 20799, 20754, 20803, 20842, 20820, 20884, 20815, 20860, 20886, 20806, 20862, 20882, 20900, 20906, 20920, 20924, 20926, 20930, 20932, 20938, 20940, 20948, 20952, 20956, 20911, 20950, 20928, 20934, 20916,	These items are for the administration of anaesthesia for various procedures.	59. No change to these items.	<b>AGREE</b>
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<p>20936, 20954, 21100, 21130,21112, 21160, 21110, 21116, 21199, 21200, 21220, 21272, 21280, 21300, 21380, 21390,21420, 21321, 21340, 21382, 21430, 21404, 21432, 21460, 21462, 21490, 21461, 21474,21482, 21484, 21522, 21502, 21532, 21530, 21600, 21680, 21620, 21670, 21682, 21654,21634, 21652, 21685, 21636, 21730, 21732, 21780, 21712, 21714, 21716, 21740, 21772,21770, 21790, 21800,</p>			
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Item	What it does	Committee recommendation	ASA Position
21820,21860, 21810, 21850, 21842,21832, 21840, 21872, 21878,21879, 21880, 21881, 21883,21884, 21885, 21886, 21887,21900, 21939, 21925, 21981,21906, 21915, 21918, 21935,21949, 21959, 21962, 21973,21976, 21980, 21908, 21914,21930, 21969, 21910, 21970,21992.			

**Other item recommendations**

Item	What it does	Committee recommendation	ASA Position – Nov 2017
13015, 13020, 13025, 13030	These items provide rebates for hyperbaric oxygen therapy, which is a medical treatment which aims to improve healing by administering 100% oxygen in a closed environment at pressures greater than atmospheric pressure. It is also used to treat decompression sickness which is a hazard of scuba diving.	60. No Change.	<b>AGREE</b>
55130, 55131, 55135, 55136	These items provide rebates for transoesophageal echocardiography, which involves the placement of an ultrasound probe in the oesophagus, which is used to generate images of the heart and large blood vessels.	61. No change.	<b>AGREE</b>
25200 and 25205	These items are for assisting anaesthetists to assist a primary anaesthetist when necessary in emergency situations.	62. No change.	<b>AGREE</b>

### General recommendations

#### Recommendation 63 RVG dollar value and indexation

*The Committee recommended that a review be undertaken into:*

*Δ The dollar value of the MBS RVG basic unit (currently \$19.80), assigned for the purpose of calculating schedule fees for the anaesthesia MBS RVG.*

*Δ Appropriate indexation for MBS items.*

**ASA Response: AGREE**