ASA
Australian Society of Anaesthetists

23 March 2017

Ms. Teresa Gorondi
Director, Medical Services Technology Section
Medical Specialist Services Branch
Medical Benefits Division
Department of Health MDP 959
GPO Box 9848
Canberra, ACT 2601

By email: hta@health.gov.au

Dear Ms. Gorondi

Medical Services Advisory Committee (MSAC) Application 1308
Local Anaesthetic Nerve Blockade for Post-Surgical Analgesia

Reference:
A. MSAC Evaluation Sub-Committee Report, Application 1308, 8 February 2017

The Economics Advisory Committee of the Australian Society of Anaesthetists (ASA) is grateful for the input of the Evaluation Sub-Committee (ESC) of MSAC into application 1308, and for the opportunity to respond to the ESC report.

The ASA has a number of concerns to relay, in particular as regards the analysis of the economic aspects of the service in question – local anaesthetic nerve blockade (LANB) for post-surgical analgesia. Also, several comments and questions repeatedly posed by the ASA during MSAC assessment processes continue to receive no response. Some of these relate to very basic aspects of the application (such as the ASA's comments, on more than one occasion, regarding the inclusion of the term "abdominal wall blocks" in the descriptor for one proposed item, seen on page 3 of the current ESC report – see ASA comments below). Other concerns are of much greater significance, however.

To continue to receive no response to genuine questions about MSAC assessment processes, nor even an acknowledgment that these questions and comments have been posed, is disappointing.

The ASA makes the following specific observations on the ESC report, and awaits MSAC's responses.

Page 1

The ASA agrees that the division of LANB into "minor" and "major" is arbitrary, and that each individual nerve block should be explicitly classified as one or the other.

The ASA again emphasises that LANB procedures involving insertion of an indwelling catheter for post-operative LA infusion, should have been considered as a whole, not just limited to paravertebral nerve

block catheters. There are certainly articles available in the literature, dealing with the benefits of nerve block catheterisation procedures as a group.

There is a spelling error in paragraph 3 (repeated in other parts of the paper). "Transversus" abdominis plane is the correct term.

<u>Page 2</u>

The ASA agrees that limiting the consideration of cost offsets afforded by LANB to the decreased use of morphine, is inappropriate. This is not merely of "concern" but is in fact a major flaw in the economic analysis. The ASA has detailed this in its response to the initial evaluation paper.

The final section of the ESC Report states that the estimated increase in MBS costs, should application 1308 be successful, would be approximately $1.86 million per annum. There is clear evidence in the literature that this cost would be significantly offset by factors such as the faster recovery times and hospital discharge resulting from the use of LANB. There is also clear evidence that the use of LANB for post-surgical analgesia results in a decrease in the incidence of chronic post-surgical pain syndromes, and emerging evidence that LANB may decrease recurrence of cancers after surgery for cancer removal.

MSAC's statement that approval of application 1308 would result in increased Medicare expenditure of $1.86 million per annum must be qualified by the fact that there will be significant cost offsets due to a number of proven clinical benefits of LANB, the economic benefits of which have not been considered by MSAC.

The Evaluation Sub-Committee of MSAC (ESC) queries the range of unit allocations to the proposed items (2-5 units). The ASA strongly believes that the proposed item for LANB with catheterisation should be allocated 5 units. Firstly, this is in line with the unit allocation to procedures of similar complexity (e.g. the placement of an epidural catheter for post-operative analgesia). Secondly, allowance must be made for post-operative follow-up. The anaesthetist responsible for the catheter must be contactable by the hospital/nursing staff for the entire duration of the LA infusion.

At the same time, the ASA is agreeable with the idea of a recalculation of costs, based on 2 units for a "minor" LANB, and 3 units for "major".

ESC states "from a consumer perspective, ESC noted that anaesthesia costs were a common cause of unexpected out of pocket (OOP) expenses for patients". The ASA expresses its frustration that, again, MSAC is prepared to make formal statements based on anecdote, with no attempt to further define such statements, nor any presentation of evidence to support them. At the same time, MSAC requires detailed evidence to back all assertions by applicants.

What incidence of OOP expenses is "common"? How often are they "unexpected"? Australian Prudential Regulation Authority (APRA) data has consistently shown that the vast majority of anaesthesia services in private hospitals result in no OOP expense to patients. Until the quarter ended December 2015 (when application 1308 was still under consideration), the situation was:

- 89% of anaesthesia services involved no OOP expense
- 6% of services were subject to a "known gap", where by definition, informed financial consent must be obtained from the patient
- Therefore only 5% of anaesthesia services <u>may</u> have resulted in OOP expenses, which <u>may</u> have been "unexpected".

Statements by MSAC regarding OOP expenses should not be made without reference to existing data.

It is also disingenuous that any group within the Department of Health is prepared to make statements about OOP expenses, without any mention of the reason such expenses exist. Medicare rebates have been subject to inadequate or even negative indexation, every year for over 30 years, and these rebates are now in the middle of an eight-year freeze on indexation.

Page 3

The descriptor for the proposed item for major LANB still contains the term "abdominal wall" blocks. As has already been stated by the ASA, the transversus abdominis plane (TAP) block is an abdominal wall block. As the TAP block has been chosen to assess the case for minor LANB, the term "abdominal wall" blocks should be removed from the proposed descriptor.

Page 4

Dot point 5 states in part "One peak body queried the exclusion of patients with chronic pain from the proposed population" and that this body states that to exclude these patients from consideration is "unreasonable".

It is important to note that application 1308 deals solely with the use of LANB for post-surgical pain relief. The services covered by application 1308 are not intended for the treatment of chronic pain conditions. Patients receiving LANB for the treatment of chronic pain would not be eligible for Medicare benefits under the proposed new LANB items, unless this service was provided in conjunction with a surgical procedure (where LANB would in fact be a recommended approach). LANB procedures for chronic pain patients are **already eligible** for Medicare funding via existing items in MBS Category Group 3, Group T7 (items 18213-18288).

Patients with chronic pain, requiring surgery for their condition, where LANB would be useful for post-operative pain relief, do indeed benefit from the LANB services covered by the proposed items, to an even greater extent than the rest of the eligible patient population. These patients would be fully eligible for Medicare rebates under the proposed new items.

Page 5

The heading to the fourth paragraph under dot point 8 should read "Systemic analgesia". The spelling error is repeated in line 3 of the paragraph, and also in the second to last line of the page, under dot point 9.

Pages 8-9

The last sentence of page 8 states, in relation to LANB infusion via an indwelling catheter, "The continuous dose includes an MBS cost of subsequent "top ups" of the local anaesthetic and is based on 15mg per hour for 48 hours".

Here, and in table 2 on page 9, several essential points made by the ASA have received no response.

- The local anaesthetic infused at "15mg per hour for 48 hours" has not been identified. This in fact does not describe any routine practice and the ASA is concerned as to where MSAC obtained this advice.

- Where a LANB catheter is placed, even though there is no Medicare funding for the LANB procedure, post-operative visits to provide LA "top ups" are already funded by Medicare, under items 18222 and 18225. The estimated MBS costs of "top ups" in table 2, covered by these items (with costs to Medicare of $28.55 and $37.55 respectively) would mean MSAC assumes each patient on average receives 7-8 separate "top up" services. **This is clearly a major overestimate of service provision and the costs involved, with no supporting evidence presented for these assumptions.**

- As the MBS already covers "top-up" services, via these two items, there would be no change whatsoever to Medicare expenditure on these items should application 1308 be successful. Medicare expenditure on these items will continue. **As there will be zero additional expenditure on items 18222-5, these costs must not be included in the analysis of the cost implications of application 1308.**

Both on page 9 and on page 10, an assumed "co-payment" has again been included in the calculations. The ASA has repeatedly requested the source of this figure, both for application 1308, and the (unsuccessful) application 1183 for the use of 2D ultrasound imaging to guide LANB and major vascular access procedures. MSAC has assumed every service is subject to this co-payment, while APRA data clearly shows that "co-payments" apply to only a minority of anaesthesia services.

The ASA again calls for MSAC to provide the exact source of this assumed "co-payment". This point is particularly concerning as it appeared to be one of the main justifications for rejecting application 1183.

Page 10

The third to last paragraph states "There may also be variability as to which proposed item (major, minor or continuous) the procedures could be claimed under…". The solution here is simple and the ASA has already stated it agrees with the approach of MSAC. An explanatory note covering all possible individual nerves amenable to LANB procedures, classifying which are considered to be "minor" or "major", is all that is required.

Page 11

The first paragraph states "It is unknown what proportion of patients will receive multiple doses of local anaesthetic for either a major or minor nerve block…", and that "it is assumed all patients receive a single dose except for those receiving a continuous catheter infusion". The ASA agrees that the vast majority of patients having a LANB procedure without a catheter will only require a single dose. However, in the rare instance of a second or subsequent LANB being performed, the procedure is already covered by Medicare, via group T7 items in the range 18213-18288. The issue of multiple single doses of LA is therefore of no relevance to the cost implications of application 1308.

It is refreshing to note that the ASA's statement that the cost offsets afforded by the deletion of items 22040-22050, should application 1308 be successful, have been detailed on page 11.

Yours sincerely,

Dr. Mark Sinclair M.B.,B.S. (Adel), F.A.N.Z.C.A.
Specialist Anaesthetist
Chair, Economics Advisory Committee
Australian Society of Anaesthetists