



Consultation Paper 9 – CIED and the cost of technical support services

Stakeholder feedback summary



Introduction

This document presents a high-level summary of stakeholder submissions to [Consultation Paper 9 - CIEDs and the cost of technical support services \(TSS\)](#) - Stage 1.

There were 31 submissions from the following sectors:

- clinicians
- technicians
- consumers
- hospitals and state government
- health insurers
- sponsors

This high-level summary highlights common matters raised by several stakeholders. It is not an analysis of stakeholder submissions and does not reflect the department's position on any of the matters raised. The matters presented here will be discussed with stakeholder groups in Stage 2 of the consultation. Readers can view individual submissions to the consultation in [Consultation Hub](#).

The common matters are split across the following topics:

- Current funding models/models of care for TSS
- Potential risks and implications of changes to current models
- Suggestions for alternative funding models/models of care.

Please note: matters that are not directly related to changes to the funding of TSS have been considered, but are not included in this high-level summary.

Current funding models/models of care for TSS

Stakeholder feedback indicated that there are several funding models/models of care for TSS. There are issues and benefits to the current models. Some examples include:

- TSS in the public sector are funded through the hospital budget which is jointly funded by state/federal arrangements. Provision of TSS in the private sector is reimbursement via the payment of benefits for the device at the time of implant (via the PL). Industry Employed Cardiac Technicians (IECTs) provide extensive support across both systems (public and private). So, whilst funding for TSS provided by IECTs comes only from the funding included in the private device PL reimbursement, TSS are provided also to public patients.
- PL and TSS benefits are often paid upfront, as TSS providers are reimbursed for CIED implants and follow ups. However, patients may not receive the follow-up TSS or may have to pay additional fees for follow-ups and checks. This leads to out-of-pocket costs and financial burden for patients. Some remote monitoring TSS are an example of this.
- Remote monitoring TSS are included in TSS for CIEDs, yet many patients are billed without receiving these services. Funding is provided through the PL benefit

at CIED implantation, regardless of the actual delivery or efficacy of TSS, and lack of data from sponsors hinder the ability to estimate average annual costs per patient.

- The current model highlights significant reimbursement issues, with some private clinics benefiting from free follow-ups by preferred TSS providers, while other providers are excluded from PL reimbursement, limiting patient options and leaving funding cross-subsidisation between public and private settings poorly quantified. The current model creates financial biases and negatively affects the workforce. Cardiac technicians are not formally recognised as health professionals and lack standardised qualifications and ongoing professional development, leading to varying levels of training and certification.
- The current model(s) blur the lines between industry-employed and non-industry physiologists, hindering workforce development and regulation. The lack of transparency creates financial biases, discouraging cardiologists from hiring their own staff.
- Some cardiac clinics and public hospitals rely on TSS provided by IECTs. Some companies have stopped providing TSS to public hospitals, causing staff reallocation and training. Rural services noted a decrease in industry support for outreach services and clinics.
- Funding through the PL ensures ongoing TSS with no out-of-pocket costs for patients, making TSS free for patients and cost-effective for manufacturers.
- Only a small proportion of the cost of devices on the PL support TSS for public patients, which is negligible in terms of private health insurance premiums. Patients currently receive TSS without out-of-pocket fees due to this model.
- Currently, there is lack of transparency and control over TSS usage and reimbursement. The degree of cross-subsidisation in patients moving between public and private in either emergency, acute or primary care settings is not well quantified.
- The actual cost of TSS is hard to determine as it is bundled with device costs.
- CIED benefits in the PL are inflated.
- The current model is expensive, inefficient, and lacking transparency.

Potential risks and implications of changes to current models

Below is a summary of the potential risks and implications of any changes to the current funding models/models of care, identified by stakeholders.

- Withdrawal of industry support may impact provision of TSS. This could leave workforce gaps and reduce provision of TSS to patients due to a lack of qualified technical resources and varying levels of training and certification. Clinicians lack the skills to fill these gaps, and no validated courses exist to upskill staff.
- Potential clinic closures, which would increase patient load on public hospitals.

- Increased administrative and financial burden on healthcare providers. Financial pressures and low admissions growth could lead to hospital closures.
- Increased out-of-pocket costs and compromised patient safety, especially in regional and remote areas, due to lack of qualified resources.
- Risk of funding the same TSS multiple times if a CIED needs replacement.
- Transitioning to a new care model would take about 12-18 months.
- Innovations in the CIED space are emerging, but the current model lacks flexibility to incorporate these advancements.
- Risks of increased patient costs, hospitalisations, worsening symptoms, and reduced economic benefits due to higher hospital costs and loss of work. Patients losing access to essential healthcare services and being forced back into the public system could lead to avoidance of necessary follow-ups.
- Changing the current model can disrupt continuity of care and hinder optimal monitoring and performance.
- Eliminating cross-subsidisation of CIED TSS through the PL benefits could lead to increased out-of-pocket costs for members, potentially causing dissatisfaction and loss of private health insurance coverage.
- Delays in implementing changes will continue to cost to consumers in projected savings.
- An alternative model that reduces or phases out the industry's role as TSS provider may impact device warranties, as companies cannot ensure programming and service standards match current models or compliance standards in device instructions.

Suggestions for alternative funding models/models of care

- An intern number billing system for TSS providers
- An annual maintenance fee to TSS providers
- Splitting reimbursement into an implant fee and a follow-up fee, allowing TSS providers to claim for implants and third-party providers to claim for follow-up TSS. This approach aims to ensure that TSS providers do not claim for TSS they do not provide.
- Create specific codes for CIED follow-up and remote monitoring and review and clarifying current Medicare item codes to enable rebates for TSS providers and accredited cardiac physiologists not employed by industry.
- Recognising accredited cardiac physiologists within the MBS and applicable national and state-level Tier 2 government funding is suggested to alleviate the burden on medical staff and encourage more personnel to join the workforce.
- Utilising MBS funding for follow-up TSS and using Medicare billing income to employ cardiac physiologists.
- Establishing direct contractual payment agreements between TSS providers and companies.

- Reallocating funds from CIED pricing to public hospital staff.
- Increasing Medicare rebates for private clinics.
- Paying a service fee to cardiac device companies.
- Using third-party contractors and training permanent hospital staff for required tasks.
- Expanding insurance coverage.
- Developing education and remote monitoring solutions by CIED manufacturers.
- The preferred option is to maintain the current model with industry agreements, with alternative funding to boost public hospital staffing and remote industry backup.
- Creation of a national CIED registry to improve transparency and accountability in TSS provision. This would help ensure accurate data collection and better oversight of TSS costs and usage
- Managing the TSS segment will add administrative and financial burdens to clinics and practices.
- Rural patients, especially the elderly, are disproportionately affected by reductions in TSS.
- The model used overseas is far superior financially and with workforce development and regulation compared to what we have in Australia.

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All information in this publication is correct as at January 2025

