



Medicare Benefits Schedule Review Taskforce

Final Report on the Review of Pain Management MBS Items

2019



Important note

This Report contains the final recommendations from the MBS Review Taskforce following the consultation of the Pain Management Clinical Committee with stakeholders. Updates made to the Clinical Committee recommendations by the Taskforce are outlined in the table below.

This report has now been forwarded to the Government for consideration.

The Taskforce welcomes ongoing feedback on this or any MBS Review report via:
mbsreviews@health.gov.au

Original recommendation	Updated recommendation
<p>Recommendation 27: Access to group therapy for pain management</p> <p>The Committee recommends:</p> <ol style="list-style-type: none"> the creation of a new item that would be one of several allied health items that could be accessed following completion of a GP chronic disease management plan or a specific chronic pain management plan, that it be accessible by medical or allied health practitioners such as nurses, physiotherapists, exercise physiologists, psychologists, or occupational therapists, and With training requirements to be determined by the relevant colleges or peak bodies. 	<p>Recommendation 27: Access to group therapy for pain management</p> <p>The Committee recommends:</p> <p>A new MBS item be created covering provision of a chronic pain management health service provided to a person by an eligible clinician being a physiotherapist, nurse, exercise physiologist, clinical psychologist or occupational therapist with training and credentialing requirements to be determined by the relevant Colleges or peak bodies as a GROUP SERVICE if:</p> <ol style="list-style-type: none"> the service is provided to a person who is part of a group of between 4 and 12 patients inclusive; and the person is not an admitted patient of a hospital; and the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner or a specialist pain management physician); and



	<ol style="list-style-type: none">4. the service is provided to a person involving the personal attendance by the eligible clinician; and5. the service is of at least 60 minutes duration; and6. eligibility is limited to up to 10 sessions in a calendar year; and7. after the last service in the group services program the eligible clinician prepares, or contribute to, a written report to be provided to the referring medical practitioner; and8. an attendance record for the group is maintained by the eligible clinician; and9. in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.
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1. Executive summary

1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

1.2 Review of the pain management items

The Pain Management Clinical Committee (the Committee) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The Committee reviewed 62 MBS items, five of which were later referred to other clinical committees for review as they more closely related to the work of those committees

In 2016/17, the 62 items accounted for approximately 650,000 services and \$52.7 million in benefits.

Pain related procedures are used by a wide variety of medical practitioners. The growth in procedures may in part be related to an attempt to reduce long-term opioid use however, some of the increase may not be in accordance with the original intention of the item.



1.3 Key Issues

Pain management is a field which touches most areas of medical practice, be it due to physical injury, disease, surgery or psychologically based. The specialty of pain medicine is a recent development, emerging to meet the needs of the increasingly complex world of today's medical practitioner and their patients. Diagnosis and treatment of pain is not straightforward and relies on an understanding of multiple interactions across the fields of biopsychosocial knowledge and practice.

As the specialism of pain management matures it is clear that the structures that support it also need to mature. The Committee's recommendations seek to assist the MBS to reflect this new environment. The recommendations cover:

- changes to the current pain management items to reflect best practice and increasing targeted use of the MBS through better clarity of descriptions and explanatory notes,
- deletions of outdated items,
- referrals to other clinical committees to ensure thorough and appropriate review,
- suggested new areas of coverage that would provide significant benefits to patient health and improve value for money across the health system, and
- where it's seen that the complete medical service could include imaging as part of clinical best practice, the Committee is of the opinion that MBS descriptors should be updated to reference this inclusion and the fee should be increased to support the consolidation of imaging options with the respective item.
- restriction of the combination of nerve block and surgical procedure item numbers in keeping with consolidation of the complete medical service. Targeted percutaneous nerve blocks will still be permitted in addition to surgical item numbers however field infiltration blocks and blocks performed under open surgical exposure will not be permitted to be co-claimed.

1.4 Key recommendations

The Committee has made some 29 recommendations across three major areas – recommendations for change, deletion and referrals and new items.

The key recommendations from each area are outlined below:

1.4.1 Recommendations for change

- Removal of co claiming of field infiltration nerve blocks or nerve blocks performed under open surgical exposure with surgical items, in keeping with the philosophy of a complete medical service.



- Revision of descriptors for spinal injections for management of chronic pain to bring greater clarity about clinical practice and also to differentiate them from radiological diagnostic procedures, which have their own item numbers.
- Addition of explanatory notes to guide best practice use of implanted devices for the management of chronic pain.

1.4.2 Recommendations for deletions and referrals

- The Committee identified a small number of obsolete items that were not reflective of current or best practice – refer to Recommendation 23.
- The Committee also identified a number of items worth reviewing over the coming years, mostly due to continuing changes in best practice or technology. Most of these are referred to within the recommendations for change.
- The Committee also referred five items to two other clinical committees as usage of those items was predominately in their specialist areas – refer to Recommendation 24.

1.4.3 Recommendations for new items

- The Committee recommends that the MBS support high value care of chronic pain, including non-cancer pain, through the support of multidisciplinary approaches including planning, monitoring and review through consultations, group pain management and telehealth. These recommendations recognise the emerging and established best practice of multidisciplinary approaches, for example Mental Health Care Planning.

1.4.4 Recommendations for future review

- The Committee recommends a number of items be further reviewed as part of a future or ongoing review process for various reasons such as:
 - to ascertain the impact of recommendations made by the PMCC,
 - to review new evidence or guidelines currently being developed/researched, and
 - to review certain items in line with themes which are overarching across the MBS as a whole, such as, the consideration to items forming, where possible, a complete medical service.



1.5 Consumer impact

All recommendations have been summarised for consumers in Appendix B – Summary for consumers. The summary describes the medical service, the recommendation of the clinical experts and the reasoning behind the recommendations. A consumer impact statement is available in Section 8.

The Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations—and how and why. Following targeted consultation with the Consumer's Health Forum, the Committee will assess the advice in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendations to Government.

Both patients and clinicians are expected to benefit from these recommendations because they address concerns regarding patient safety and quality of care, and because they take steps to simplify the MBS and make it easier to use and understand. In addition, the Committee's recommendations promote the provision of higher value medical care, which can reduce unnecessary medications, procedures and related out-of-pocket fees for patients, while supporting access to modern effective procedures.

1.6 Next Steps

The MBS Taskforce considered the report and feedback from stakeholders and endorsed the Pain Management Clinical Committee Draft Report to the Minister for Health, for Government consideration.



2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme. It enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items, which provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the MBS Review Taskforce (the Taskforce) as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review (the Review) is clinician-led, and there are no targets for savings attached to the review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of four key goals:

- **Affordable and universal access** — the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist



workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-served.

- **Best practice health services** — one of the core objectives of the MBS Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient** — another core objective of the MBS Review is to support the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system** — achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.



The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria (Elshaug, 2016). The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value,¹ are misused² and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2" or "priority 3", using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise a clinical review report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the Review. However, given the breadth of the review and its timeframe, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria (Elshaug, 2016):

¹ The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

² The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.



- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).



3. About the Pain Management Clinical Committee

The Pain Management Clinical Committee (the Committee) was established in June 2018 to make recommendations to the Taskforce on MBS items within its remit, based on rapid evidence review and clinical expertise.

3.1 Pain Management Clinical Committee members

The Committee consists of 17 members, whose names, positions/organisations and declared conflicts of interest are listed in [Table 1](#).

Table 1: Pain Management Clinical Committee members

Name	Position/organisation	Declared conflict of interest
Dr Chris Hayes	Director of Hunter Integrated Pain Service; specialist pain medicine physician, immediate past Dean, Faculty of Pain Medicine, Australia and New Zealand College of Anaesthetists.	Board member Painaustralia, co-Chair Clinical and Management Advisory Committee of the electronic Persistent Pain Outcomes Collaboration (ePPOC), Chair Faculty of Pain Medicine's Research and Innovation Committee, member of NSW Agency for Clinical Innovation Pain Network Executive
Dr Lindy Roberts	Specialist anaesthetist and specialist pain medicine physician; former President, Australian and New Zealand College of Anaesthetists.	Part-time employee (8hrs/week) of the Australian and New Zealand College of Anaesthetists.
A/Prof Carolyn Arnold	Specialist Pain Medicine Physician and also in Rehabilitation Medicine; past President, Australian Pain Society.	Nil
Dr Marc Russo	Specialist pain medicine physician; founding member and current Secretary of the Australian Chapter of the International Neuromodulation Society.	Managing director of a pain clinic in Newcastle, NSW.
Dr Tim Semple	Anaesthetist and specialist pain medicine physician; past President Australian Pain	Previously on the board of Australian Pain Society.



Name	Position/organisation	Declared conflict of interest
	Society; board member Painaustralia; current President, Australian Pain Relief Association.	
Dr Andrew Zacest –	Consultant neurosurgeon; Clinical Associate Professor, University of Adelaide; board member, Faculty of Pain Medicine (ANZCA).	Nil
Adj/Prof Richard Chye -	Pain and palliative medicine physician; Director, Sacred Heart Supportive and Palliative Care.	Currently a Fellow at the Pain Faculty in Sydney.
Dr Graham Rice	Specialist pain medicine physician, psychiatrist and anaesthetist; foundation board member, Faculty of Pain Medicine (ANZCA).	On the Australian Pain Society board and helped develop the Queensland Work Cover guidelines.
Prof Michael Nicholas	Professor and clinical psychologist, Pain Management Research Institute, University of Sydney at Royal North Shore Hospital.	Author, Manage Your Pain.
Dr Ian Thong	Specialist pain medicine physician and former GP; Medical director of Persistent Pain Services, Gold Coast University hospital.	Director of Pain Services at Gold Coast Hospital and a former rural GP.
Dr Gus Ferguson	Interventional and general radiologist.	Nil
Mr John Stubbs	Member, Medical Services Advisory Committee (ESC); consumer representative.	Developing cancer pain guidelines with the Cancer Institute of Australia.
Ms Lesley Brydon	Founding CEO of Painaustralia; consumer representative.	Founding CEO of Painaustralia, Executive Director of the National Pain Summit and long term pain patient.
Dr Marilla Druitt	Gynaecologist Obstetrician, Persistent Pelvic Pain Clinic University Hospital Geelong.	Obstetrician specialising in laparoscopic surgery and endometriosis; works at a public pain clinic. Affiliations with the Pelvic Pain Foundation of Australia and International Pelvic Pain Society.
Dr Lee Gruner	Immediate past President of the Royal Australasian College of Medical Administrators, Taskforce ex officio.	Nil
Prof Michael Besser -	Neurosurgeon, Taskforce surgical ex officio.	Nil



Name	Position/organisation	Declared conflict of interest
A/Prof Tillman Boesel	Specialist pain medicine physician with expertise in neuropathic pain, and interventional pain therapies.	Medical Director of pain management practice

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations at the beginning of each committee or working group meeting. A complete list of declared conflicts of interest can be viewed in Table 1 above.

It is noted that the majority of the Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Committee members claim the items under review). This conflict is inherent in a clinician-led process and, having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review of items.

3.3 Areas of responsibility of the Committee

The Committee reviewed 62 MBS items, five of which were later referred to other clinical committees for review as they more closely related to the work of those committees

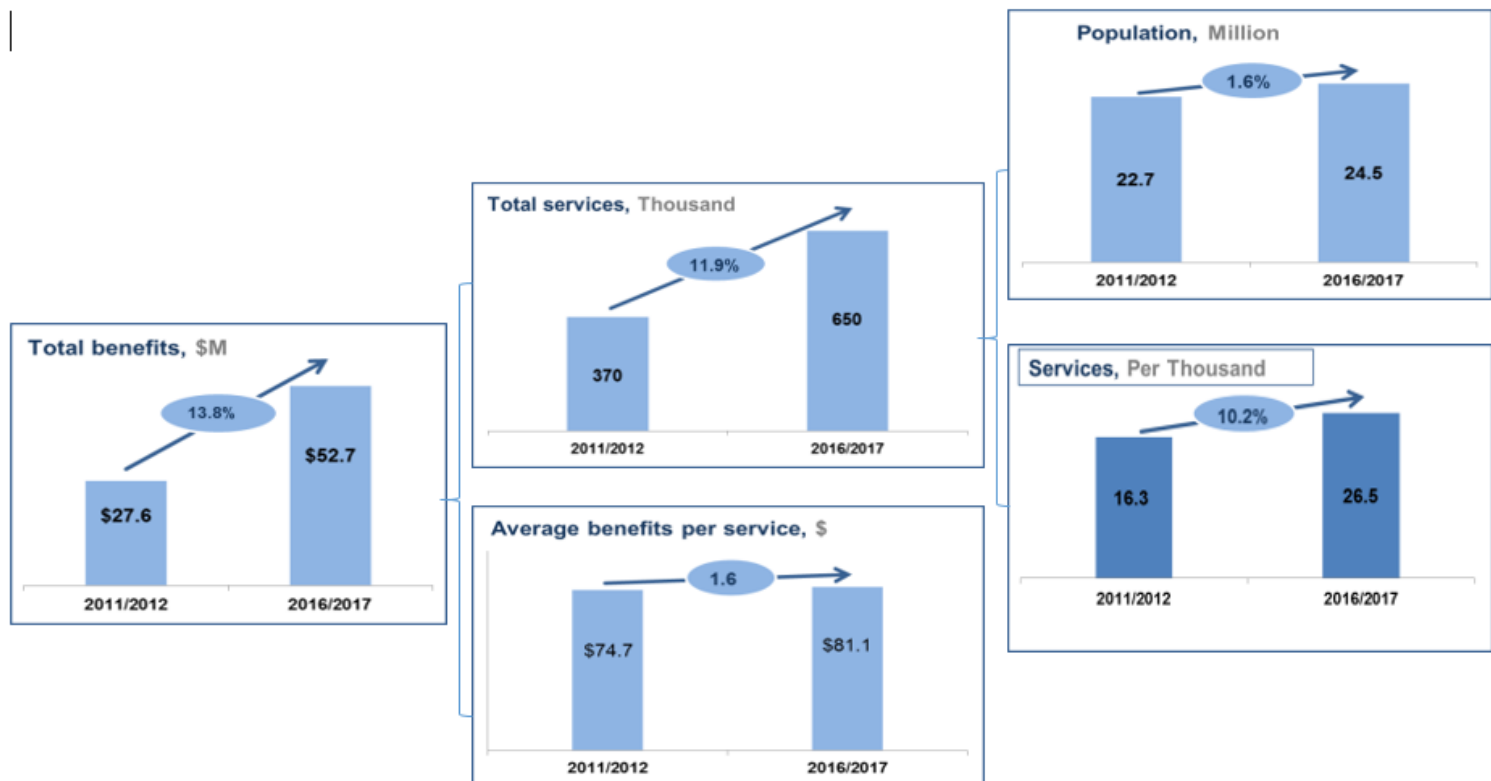
Many of the items assigned to the Committee are predominantly used by specialty groups beyond pain medicine including diagnostic radiologists, neurosurgeons, GPs, general surgeons, anaesthetists, cardiothoracic surgeons, orthopaedic surgeons, ENT specialists, haematologists, ophthalmologists, plastic and reconstructive surgeons, palliative care specialists, vascular specialists and rehabilitation specialists.

The items allocated to the Committee to review were determined with consideration of advice from the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (ANZCA).

The rising service of pain related procedures is not due to an increased number of people with pain. In part the trend may reflect an attempt to provide alternative treatment to long term opioids. However, it is also possible that some increase in use may not have been in accordance with the original intention of the item number and may not reflect best practice.



Figure 1: pain management item growth - 2011/12–2016/17



Percentage increase represents the average compound annual growth rate.

Source: Publicly available data from Department of Human Services and Australian Bureau of Statistics. All items in the Pain Management Clinical Committee scope, 2011-12 and 2016-17, by date of processing. The graph covers all 62 items reviewed prior to 5 items being referred.

3.4 Summary of the committee's review approach

The Committee completed a review of its items across five full committee meetings (two teleconferences and three in-person meetings). There were three working groups formed to consider specific areas of the MBS grouped by the type of procedures:

- nerve block and spinal injections,
- surgical co-claiming, and
- implanted devices.

Members self-nominated by area of interest and expertise, with membership of each working group outlined in the table below. Each working group had one meeting and provided draft recommendations to the committee for the items within their remit.

**Table 2: Working Group Memberships and Items Considered**

ITEMS	Working Group	Members
14209, 18213, 18222, 18225, 18230, 18234, 18240, 18242, 18248, 18250, 18256, 18258, 18260, 18268, 18274, 18276, 18282, 18284, 18286, 18290, 18292, 18294, 18296, 18298, 39013, 39100, 39115, 39118, 39121, 39124, 39140, 39323	Nerve Blocks and Spinal Injections	Dr Gus Ferguson Dr Marc Russo Dr Andrew Zacest Assoc Prof Tillman Boesel
18228, 18232, 18234, 18236, 18238, 18244, 18252, 18254, 18262, 18264, 18266, 18270, 18272, 18278, 18280, 18288	Surgical Co-Claiming	Dr Lindy Roberts, Dr Marilla Druitt Dr Tim Semple Dr Ian Thong Dr Andrew Zacest Assoc Prof Tillman Boesel Dr Marc Russo
14218, 14221, 39125, 39126, 39127, 39128, 39130, 39131, 39133, 39134, 39135, 39136, 39137, 39138, 39139	Implanted Devices	Prof Michael Nicholas Assoc Prof Tillman Boesel Assoc Prof Caroline Arnold Dr Andrew Zacest Dr Marc Russo

Recommendations and rationales contained in this report were developed during these meetings.

The review drew on various types of MBS data, including:

- data on utilisation of items (services, benefits, patients, clinicians and growth rates),
- service provision (type of clinician, geography of service provision),
- patients (demographics and services per patient),
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time), and
- additional clinician and patient-level data, when required.



The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical journals and other sources, such as professional societies.

In addition, the Committee and its relevant stakeholder groups agree that persistent pain is a chronic illness and treatment should focus on management and functional gains rather than treating the pain alone (Wan, August 2014). Consultations with specialist pain medicine physicians, and allied health professionals, as well as the development of multidisciplinary care plans and treatment pathways, are central to effectively managing chronic pain. This broad approach is equally applicable to cancer related pain and in preventing the progression of acute pain to chronicity. Consultation items, including multidisciplinary care and care planning items have been allocated to other clinical committees, working groups or reference groups of the Review. The Committee believes these elements are consistent with the terms of reference of the Review as a whole.

3.5 No change

The Committee's examination indicated a number of items where there were no concerns regarding safety, access, value or contemporary best practice.

Also, the Committee determined that there was continuing best practice use of certain items for rare conditions even if usage was identified as low. The items identified by the Committee for no change are listed below in Table 3.

Table 3: Items identified as requiring no change

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent	\$93.60	9641	\$805,730	-4.3
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)	\$37.65	5658	\$195,475	77.2
18248	PHRENIC NERVE, injection of an anaesthetic agent	\$88.65	1	\$67	0



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent	\$62.50	19	\$955	-1.0
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent	\$62.50	3,036	\$152,369	13.5
18268	OBTURATOR NERVE, injection of an anaesthetic agent	\$88.65	119	\$8,604	22.6
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	\$124.85	18,668	\$1,888,203	9.8
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	\$176.00	66	\$9,869	12.9
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	\$631.75	0	0	0
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)	\$1,616.80	0	0	0
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)	292.85	5,407	1,046,392.11	11.0%



4. Recommendations for change

4.1 Nerve Blocks and Spinal Injections

Table 4: Nerve Blocks and Spinal Injections items considered by working group

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	\$88.70	873	\$72,229	12.1
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion	\$88.65	399	\$29,350	-3.6
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less	\$37.65	28107	\$87,9078	4.7
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes	\$50.05	21186	\$869,251	12.9
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)	\$238.45	5290	\$1,052,630	5.8
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) anaesthetic, steroid not being a service to which another item in this Group applies (Anaes.)	\$189.90	34,385	\$5,444,264	11.9
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)	\$124.85	13,888	\$1,442,771	21.9%



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent	\$93.60	9641	\$805,730	-4.3
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)	\$37.65	5658	\$195,475	77.2
18248	PHRENIC NERVE, injection of an anaesthetic agent	\$88.65	1	\$67	0
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent	\$62.50	19	\$955	-1.0
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent	\$62.50	3,036	\$152,369	13.5
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent	\$62.50	435	\$21,925	-1.7
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent	\$88.65	4,719	\$320,622	16.4
18268	OBTURATOR NERVE, injection of an anaesthetic agent	\$88.65	119	\$8,604	22.6
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)	\$88.65	63,985	\$4,816,805	13.6
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure	\$100.80	28	\$2,139	25.5
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)	\$147.65	122	\$13,750	-1.1
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)	\$147.65	2,289	\$353,964	3.1
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a	\$249.75	6	\$1,199	14.9



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
	service associated with the injection of botulinum toxin (Anaes.)				
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)	\$124.85	344	\$35,939	14.1
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	\$176.00	74	\$9,862	-0.5
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	\$150.55	122	\$14,103	1.0
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	\$176.00	66	\$9,869	12.9
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.)	\$109.15	54,495	\$4,706,643	9.7
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)	\$237.60	106	\$20,522	-41.7
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or trigonal nerve block (payable once only in a 30 day period) (Anaes.)	\$75.30	67	\$4,190	-11.2
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)	\$297.85	68,808	\$7,289,868	19.7
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	\$631.75	0	0	0



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)	\$1,616.80	0	0	0
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.)	\$276.80	17,417	\$1,807,800	28.4

4.1.1 Recommendation 1 – Clarifying item 18213 - intravenous regional anaesthesia

The Committee recommends:

- a. Deleting item number 14209
- b. Amending item 18213 descriptor to:

Item 18213

INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion of local anaesthetic agent.

4.1.1.1 Rationale 1

The items 14209 and 18213 provide for intra-arterial infusion or retrograde intravenous perfusion of a sympatholytic agent and intravenous regional anaesthesia of limb by retrograde perfusion respectively.

This recommendation focuses on ensuring best practice based on scientific evidence and increasing clarity. It is based on the following assessment:

- The Committee considered that item 14209 was no longer required as current scientific evidence does not support the use of a sympatholytic agent as described in 14209. With the removal of “sympatholytic agent” from the item descriptor, this item becomes redundant. The Committee were of the opinion that the item may be



being inappropriately used for regional anaesthetic of a limb which is covered by item number 18213.

- The Committee believes it's more appropriate for providers to use item 18213, for retrograde intravenous perfusion as the use of local anaesthetic for pain management has benefit in select cases.
- The Committee believes that item 18213 remains as contemporary clinical best practice in select cases and that the descriptor change will clarify that other agents are not supported by the evidence.

4.1.2 Recommendation 2 – Clarifying items 18222 and 18225 - continuous infusion by catheter

The Committee recommends amending the item descriptors to (additions in bold):

Item 18222

Continuous infusion **or injection by catheter** of a therapeutic substance (**not contrast agent**) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less.

and

Item 18225

Continuous infusion **or injection by catheter** of a therapeutic substance (**not contrast agent**) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes.

4.1.2.1 Rationale 2

This recommendation focuses on increasing clarity of intended use of the items and ensuring value for the health system. It is based on the following assessment:

- The Committee was of the opinion that these items are at times being used when injecting contrast in diagnostic radiology procedures despite this not providing regional anaesthesia and when there are adequate numbers available for those procedures.



- The Committee considers that amending the descriptors will ensure that these items are not used for diagnostic radiology purposes.

4.1.3 Recommendation 3 – Clarifying item 18230 - intrathecal or epidural injection of neurolytic substance

The Committee recommends amending the item descriptor to (additions in bold):

Item 18230

INTRATHECAL or EPIDURAL INJECTION of neurolytic substance **(not contrast agent) by any route, including transforaminal, for the palliative treatment of pain (Anaes.)**

4.1.3.1 Rationale 3

This item provides for intrathecal or epidural injection of neurolytic substance.

This recommendation focuses on increasing the clarity of its intended use and ensuring greater value for the health system. It is based on the following assessment:

- The Committee are of the opinion that amending the descriptors will ensure the use of this item is not for diagnostic radiology procedures that use contrast. The item should not be used for diagnostic radiology purposes as adequate item numbers already exist for that practice and contrast is not a neurolytic substance.
- Diagnostic radiology procedures will be specifically excluded from this item and item 18232.
- Intrathecal injection of contrast is already adequately covered by myelography item numbers (56219, 56259, 59724, 59725³). Item 18232 has a lower fee which is justified by the Committee as they consider this is the appropriate item number for non-neurolytic epidural injection.
- In amending the descriptor, the Committee have added additional information in relation to route and treatment in order to better clarify the item scope and encourage appropriate claiming.

³ Refer to MBS Online at

<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home>



4.1.4 Recommendation 4 – Clarifying item 18232 - intrathecal or epidural injection of non-neurolytic substances

The Committee recommends:

- a. expanding this descriptor to include epidural injection with local anaesthetic and steroid and chemotherapy agents, specifically including the transforaminal route (additions in bold):

Item 18232

INTRATHECAL or EPIDURAL INJECTION, **(including translaminar and transforaminal approaches), of therapeutic substance(s) (anaesthetic, steroid or chemotherapeutic agents)**, not being a service to which another item in this Group applies (Anaes.)

- b. Amending item 18230 (removing contrast) may result in epidural contrast injection being absorbed by revised item 18232. There is a decrease in fees associated with this absorption which is justified by the Committee as they consider this is the appropriate item number for this portion of the procedure. The Committee estimates that there will be a 10% increase in claims for item 18232 as a result of this absorption.

Note: see also Recommendation 24 for further recommended changes

4.1.4.1 Rationale 4

This recommendation focuses on increasing the clarity of its intended use and ensuring greater value for the health system. It is based on the following assessment:

- The Committee consider that amending the descriptors for items 18232 (and 18230 – refer to Recommendation 3) will provide item numbers that clearly incorporate the high volume service of transforaminal epidural injection that is currently being claimed by some practitioners under item 18230.
- Currently there is not a clear item number for transforaminal epidural injections. By making this item descriptor clear (item 18232), and modifying other items to exclude usage for this purpose, clarity is provided about the type of service and a more appropriate fee applied.



4.1.5 Recommendation 5 – Clarifying item 18284 - sympathetic chain (including stellate ganglion)

The Committee recommends amending the descriptor to (additions in bold):

Item 18284

Cervical or thoracic sympathetic chain injection of an anaesthetic agent (Anaes.)

4.1.5.1 Rationale 5

This recommendation focuses on clarifying intended use to reflect practice across items. It is based on the following assessment:

- This change brings the local anaesthetic items into alignment with the neurolytic sympathetic chain blocks.
- The clinical opinion of the Committee is that thoracic sympathetic chain local anaesthetic blocks are currently already being claimed under item 18284 as the stellate ganglion sits in the cervicothoracic region. This reflects the comparable technical difficulty of the procedure at cervical and thoracic levels.
- The recommended change will simply provide a more accurate description of current practice.

4.1.6 Recommendation 6 – Clarifying item 18286 - pelvic sympathetic blocks

The Committee recommends amending the item descriptor to (additions in bold):

Item 18286

LUMBAR or **PELVIC SYMPATHETIC CHAIN**, injection of an anaesthetic agent (Anaes.)

4.1.6.1 Rationale 6

This recommendation focuses on clarifying appropriate use of items, and ensuring greater value for the health system. It is based on the following assessment:

- The clinical opinion of the Committee is that the pelvic region is already currently being claimed under this item number and doesn't anticipate any increase in claiming practices as a result of this recommendation.



- The Committee are aware that pelvic sympathetic blocks are already claimed under item 18286 due to there not being another appropriate item number for use.
- Pelvic sympathetic blocks are considered to have the same evidence base for utility as other sympathetic blocks
- This suggested change will bring the local anaesthetic items into alignment with the neurolytic sympathetic chain blocks.
- Blockade of lumbar paravertebral nerves should in future be claimed under 18276, which the committee sees as more appropriate.

4.1.7 Recommendation 7 – Reflecting best practice in items 18290 -18294 - neurolytic agent treatment

The Committee recommends amending the item descriptors to (additions in bold):

Item 18290

CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent (**under image guidance**), not being a service associated with the injection of botulinum toxin

and

Item 18292

NERVE BRANCH, destruction by a neurolytic agent (**under image guidance**), not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)

and

Item 18294

COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (**under image guidance**) (Anaes.)



4.1.7.1 Rationale 7

This recommendation focuses on recognising current best practice in the items. It is based on the following assessment:

- The Committee considers adding 'under image guidance' to the item numbers will improve safety for patients as it is currently accepted best practice to perform these procedures under image guidance (Mercadante, Klepstad, Kurita, & al, 2015).

4.1.8 Recommendation 8 – Clarifying item 18296 - pelvic region of the sympathetic chain

The Committee recommends amending the item descriptor to (additions in bold):

Item 18296

LUMBAR **OR PELVIC** SYMPATHETIC CHAIN, destruction by a neurolytic agent (**under image guidance**) (Anaes.)

4.1.8.1 Rationale 8

This recommendation focuses on recognising current best practice in the items. It is based on the following assessment:

- There is currently no item number which provides access to the pelvic region of the sympathetic chain for neurolytic injection. The Committee considers it is likely that pelvic sympathetic chain neurolytic blocks are currently being performed using this item number.
- This change will reduce confusion with billing practices and is not expected to change the number of claims per year.
- Pelvic sympathetic chain destruction by a neurolytic agent is considered to have the same evidence base for utility as other sympathetic blocks (Gunduz & Kenis-Coskun, 2017) .



4.1.9 Recommendation 9 – Reflecting best practice in item 39013 - intra-articular injection

- a. The Committee recommends amending the item descriptor to (additions in bold):

Item 39013

INJECTION **UNDER IMAGE GUIDANCE** with 1 or more of contrast media, local anaesthetic or steroid into 1 or more zygapophyseal or costo-transverse joints. (Anaes.)

- b. The Committee recommends amending the explanatory notes for item 39013 to include the following statement “Where intra-articular zygapophyseal joint injection provides a short term effect that is repeatedly observed, consideration should be given to longer lasting pain management techniques.”
- c. The Committee recommends creation of new item 39014

New item 39014

Medial branch block of primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes)

4.1.9.1 Rationale 9

This recommendation focuses on recognising current best practice and improving patient safety. It is based on the following assessment:

- The Committee recommends deleting ‘1 or more primary posterior rami of spinal nerves’ and replacing ‘under image intensification’ with ‘under image guidance’. This will make the item number applicable only to intra-articular injection.
- There is currently widespread claiming of this item number for diagnostic medial branch blocks which the Committee considers is better addressed by splitting 39013, with item number 39014. These changes will restrict diagnostic medial branch blocks to item 39014. As a result use of item 39013 is expected to decrease.
- The proposed change will provide greater clarity about current practice. It will differentiate medial branch block (as a prelude to radiofrequency neurotomy) which is well supported by scientific evidence from intra-articular zygapophyseal joint block which is less well supported.
- The Committee is of the opinion that adding ‘under image guidance’ will improve safety for patients. Co-claiming data reflects that in 80% of cases imaging is being



performed when undertaking this procedure, therefore it is currently accepted best practice to perform these procedures under image guidance.

- The Committee considered restricting use of CT guidance with this item (due to concerns about safety and radiation exposure) however; it determined that there was sufficient evidence to support the safety and efficacy of CT guidance. The Committee recommends that item 39013 be reviewed in 2 years.

4.1.10 Recommendation 10 – Clarifying item 39100 - trigeminal nerve neurolytic block

The Committee recommends amending the item descriptor to (additions in bold):

Item 39100

INJECTION OF A PRIMARY BRANCH OF TRIGEMINAL NERVE (**ophthalmic, maxillary or mandibular branches**) with alcohol, phenol, or similar **neurolytic** substance (**under image guidance**) (Anaes.)

4.1.10.1 Rationale 10

This recommendation focuses on improving patient safety and reflects best practice. It is based on the following assessment:

- The recommendation's intention is to provide clarity around what is considered as a 'primary branch' of the trigeminal nerve as there are three major branches.
- The Committee were of the opinion that adding 'under image guidance' to the above item number to improve safety for patients.
- The Committee also considers that use of image guidance is current best practice (Zakrzewska J.M., 2011).

4.1.11 Recommendation 11 – Clarifying item 39118 - percutaneous neurotomy

The Committee recommends:

- a. removing the assistant fees associated with this item,
- b. change wording from 'facet' to 'zygapophyseal' joint to achieve consistent wording with item 39013, and neurotomy to denervation for clarity.
- c. five additional new items be created covering the:



- Three regions of the spine (cervical, thoracic, lumbar) and,
 - Left and right sides of the body,
- d. a restriction of three episodes per year for each region of the spine and side of the body, whereby an individual could potentially claim up to 18 episodes per year in total across the left and right sides of the body and the spinal regions,
- e. an increase in MBS fee for the cervical region of the spine due to the risk and complexity involved in performing this procedure in that area of the spine being greater than that of other areas,
- f. An addition made to the explanatory notes regarding the preference for thermal radiofrequency in the majority of circumstances and the limited uses for pulsed radiofrequency: Clear distinction should be made between thermal (continuous) radiofrequency neurotomy and pulsed radiofrequency of the medial branch of the dorsal rami of spinal nerves for treatment of zygapophyseal pain. The patient should be made aware of,
- (1) which modality is being used,
 - (2) what longevity of response is expected,
 - (3) the mechanism involved - thermal produces a lesion, and therefore completely, interrupts the nociceptive signal, while pulsed does not,
 - (4) technical details - thermal radiofrequency uses a higher temperature (70 - 85 degrees centigrade). Pulsed RF uses a lower temperature (42 degrees), and
 - (5) evidence base - thermal has a proven track record with a response of up to 12 months. The response to pulsed RF is less predictable and of shorter duration (several weeks at best).
 - (6) indications for pulsed RF – pulsed RF may be indicated in select situations when anatomic abnormality precludes the correct positioning of a thermal radiofrequency probe.
 - (7) cost - although the outcomes differ significantly, both techniques attract the same MBS rebate.
- g. the new item descriptors be (additions in bold):

Item 39118

LEFT CERVICAL PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)



and

New Item

RIGHT CERVICAL PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)

and

New Item

LEFT THORACIC PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)

and

New Item

RIGHT THORACIC PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)

and

New Item

LEFT LUMBAR PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)

and

New Item

RIGHT LUMBAR PERCUTANEOUS zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)

- h. The Committee considered restricting use of CT guidance with this item (due to concerns about safety and radiation exposure) however it was determined that the evidence supports the use of CT in this context. The Committee recommends that this item be reviewed in 2 years.



4.1.11.1 Rationale 11

This recommendation focuses on improving patient safety, reflects best practice and effective use of the health system. It is based on the following assessment:

- The Committee does not consider that an assistant is needed for this procedure and patient safety will be maintained without it.
- The new items would result in five new item numbers being created (including the original number, the total for this procedure would be 6 item numbers).
- The Committee has noted the claiming practices of this item and determined that claiming is occurring which could be the result of unnecessary treatments being performed, or not performed correctly initially. If performed correctly thermal radiofrequency should last at least 5 or 6 months, therefore the Committee maintains that it is not justified to repeat the procedure inside a timeframe of less than 4 months. (Abdurrahman Çetin and Abdulkadir Yektaş, 2018) Pulsed radiofrequency has a limited role in medial branch procedures but is still the technique of choice in carefully selected situations, which will still be enabled under the recommended changes.
- The surgical three-item rule may encourage procedures to be performed over multiple days, therefore the Committee recommendation is to restrict claiming for this procedure to three episodes in a calendar year for a specified pain region of the spine to encourage quality patient experience and safety and ensuring that the MBS aligns with best practice professional standards.
- For the purposes of communicating the intent of the term 'episodes', in the context of the Committee and this report, the Committee uses the term 'episodes' to mean *'a treatment or related multiple treatments administered by a physician during a single visit for a diagnosed condition'*.
- Pulsed Radiofrequency denervation is considered to have very limited value in the management of chronic pain and use of thermal radiofrequency modalities should be encouraged) (Pangarkar, 2014) However, the committee considered that there are some specific situations where pulsed radiofrequency still has value and that these should be outlined in the explanatory notes to guide best practice.



4.1.12 Recommendation 12 – Reflecting best practice in item 39323 - percutaneous denervation

The Committee recommends:

- a. removing the assistant fees for this item
- b. restricting access to 6 episodes of care for a given nerve in a calendar year, and
- c. amending the descriptor to (changes in bold):

Item 39323

PERCUTANEOUS DENERVATION (**excluding medial branch nerve**) by cryotherapy or radiofrequency **probe**, not being a service to which another item applies (Anaes.)

4.1.12.1 Rationale 12

This item provides for percutaneous denervation by cryotherapy or radiofrequency probe.

This recommendation focuses on improving patient experience, reflects best practice and effective use of the health system. It is based on the following assessment:

- The Committee considers the change to the descriptor will encourage quality patient experience and ensure that the MBS aligns with professional standards.
- The Committee is of the opinion that item 39323 should be restricted to six episodes for a given nerve in a calendar year. Both thermal and pulsed radiofrequency have current clinical applications in this setting.⁴
- The Committee does not consider that an assistant is needed for this procedure and patient safety will be maintained without it.
- It is not clinically appropriate for item 39323 to have a recommendation for restricting CT guidance.

⁴ Refer to Table 4 of this report



4.2 Implanted Devices

Table 5: Implanted Device items considered by working group

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	\$97.95	1,866	\$149,224	-8.2
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies	\$52.50	140,084	\$5,778,204	7.1
39125	Intrathecal or SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.)	\$298.05	16	\$3,242	-8.5
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.)	\$361.90	59	\$15,808	-11.2
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.)	\$473.65	17	\$6,032	-11.3
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.)	\$659.95	53	\$25,466	-1.8



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.)	\$674.15	3,337	\$1,226,087	28.0
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day	\$127.80	5,401	\$566,384	21.1
39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or SPINAL CATHETER, for the management of chronic intractable pain (Anaes.)	\$159.40	39	\$3,752	-4.8
39134	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)	\$340.60	1,332	\$188,120	15.0
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)	\$159.40	414	\$34,191	17.5
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)	\$159.40	1,314	\$89,274	10.4



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.)	\$605.35	308	\$113,272	12.9
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.)	\$674.15	2,667	\$932,760	11.5
39139	EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)	\$905.10	95	\$55,111	3.5

4.2.1 Recommendation 13 - Clarifying item 14218 - infusion pump refilling

The Committee recommends amending the item descriptor to (changes in bold):

Item 14218

IMPLANTED INFUSION PUMP REFILLING OF reservoir with therapeutic agent(s) for infusion to the subarachnoid space **or accessing the side port to assess catheter patency**, with or without pump re-programming, for the management of chronic pain, **including cancer pain.**



4.2.1.1 Rationale 13

This recommendation focuses on effective use of the health system. It is based on the following assessment:

- The amendments to the descriptor are intended to provide clarity around claiming practices and appropriate use of the item numbers.
- Currently, Specialist Pain Medicine Physicians use item 14221 occasionally to allow side-port access to assess catheter patency. This is a procedure that is considered of equivalent technical difficulty to item 14218. Both side port access and pump refill (this item) relate to a device infusing into the subarachnoid space. Item 14221 is generally used for the accessing of less complex devices infusing into the venous circulation. Therefore adding the infrequently used side port access and so including this procedure in item 14218 is considered appropriate despite the increase in fee.
- There is expected to be a small decrease (estimated 5%) in the number of claims against item 14221 and an equivalent rise in item 14218.
- The epidural route of drug administration is no longer used for implanted infusion pumps due to inconsistent spread of infusate and the higher risk of catheter tip fibrosis.

4.2.2 Recommendation 14 – Clarifying items 39125 to 39128 and items 39133 and - infusion pump

The Committee recommends:

- a. amending the item descriptors to (changes in bold):

Item 39125

SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic pain, **including cancer pain** (Anaes.) (Assist.)

and

**Item 39126**

INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to a spinal catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic pain, **including cancer pain** (Anaes.) (Assist.)

and

Item 39127

SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic pain, **including cancer pain** (Anaes.)

and

Item 39128

INFUSION PUMP, subcutaneous implantation of, AND SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic pain, **including cancer pain** (Anaes.) (Assist.)

and

Item 39133

Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of SPINAL CATHETER, for the management of chronic pain **including cancer pain** (Anaes.)

and

- b. these item numbers be reviewed in 2 years as recommendations for clinical use are changing and because of the development of new therapeutic agents that may use these routes of delivery.

4.2.2.1 Rationale 14

This recommendation focuses on effective use of the health system. It is based on the following assessment:

- The amendments are intended to provide clarity around claiming practices and appropriate use of the item numbers. While cancer related pain is not currently



excluded by these descriptors, there is confusion in some minds about if they are applicable. Use of these procedures in the treatment of selected cancer pain cases (Davies, 2018) is considered best practice (Zheng, He, & Yang, 2017) (Smith, et al., 2002).

- While there is only minor use of the epidural catheters under these item numbers, it is still appropriate. There is no known inappropriate use of the item numbers that requires this level of specification and so articulation of the specific placement of the spinal catheter has been removed.

Note: Additional changes are suggested for several of these item numbers – see below.

4.2.3 Recommendation 15 – Clarifying items 39131, 39134, 39135, 39136, 39137 and 39139 - neurostimulator

The Committee recommends amending item descriptors to (changes in bold):

Item 39131

ELECTRODES epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator **with a medical practitioner attending**, for the management of chronic neuropathic pain or pain from refractory angina pectoris - each day (Anaes.)

and

Item 39134

NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic neuropathic or pain from refractory angina pectoris (Anaes.) (Assist.)

and

Item 39135

NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, **open surgical removal of**, performed in the operating theatre of a hospital (Anaes.)(assist)

and

**Item 39136**

LEAD epidural or peripheral nerve that was **implanted** for the management of chronic neuropathic pain or pain from refractory angina pectoris, **open surgical removal of**, performed in the operating theatre of a hospital (Anaes.)(assist)

and

Item 39137

LEAD, epidural or peripheral nerve that was **implanted** for the management of chronic neuropathic pain or pain from refractory angina pectoris, **open surgical repositioning** to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.)(assist)

and

Item 39139

EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)

4.2.3.1 Rationale 15

This recommendation focuses on effective use of the health system. It is based on the following assessment:

- Adding ‘open surgical removal’ or ‘open surgical repositioning’ and “implanted” instead of “inserted” emphasises the open surgical nature of these procedures and prevents the items from being inappropriately claimed when removing or repositioning leads percutaneously, which is a much simpler and quicker procedure.
- These open surgical procedures are of equivalent technical challenge and for reasons of patient safety the Committee recommends the use of a surgical assistant.
- The word ‘intractable’ is poorly defined and the Committee considers that it does not add clarity to these descriptors.



4.2.4 Recommendation 16 – Clarifying items 39130 and 39138 – Lead placement

The Committee recommends:

- a. Amending the item descriptors to (changes in bold):
- b. One additional new item 39129

New Item 39129

PERIPHERAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (Anaes.)

and

Item 39130

EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (Anaes.)

and

Item 39138

PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain **where the leads are intended to remain in situ long term** (Anaes.) (Assist.)

4.2.4.1 Rationale 16

This recommendation focuses on effective use of the health system and patient safety. It is based on the following assessment:

- The amendments are intended to provide clarity around claiming practices and appropriate use of the item numbers.
- The word ‘intractable’ is poorly defined and the Committee considers that it does not add clarity to these descriptors.
- The three item rule currently being considered at the Principles and Rules Committee will supersede the ‘maximum of 4 leads’ rule.
- The addition of ‘where the leads are intended to remain in situ long term’ to item 39138 is designed to clarify the intended use of the item and seek to stop the item



being inappropriately claimed, e.g. for Percutaneous Electrical Nerve Stimulation procedure (placement of an electrode for 20-30 mins with pulsed therapy delivered and then leads removed).

- Currently there is no item for peripheral lead percutaneous placement (there is an item for surgical placement). It is possible that practitioners currently use 39130 or 39138 for this purpose. Our suggested change will bring greater clarity of current practice. It will also enable the use of an appropriately lower fee for percutaneous peripheral lead placement.

4.2.5 Recommendation 17 – Further review of item 14221 - devices infusing into the venous system

The Committee recommends that item 14221 be further reviewed noting the issues are outside the remit of the Committee.

Note: Currently, Specialist Pain Medicine Physicians use item number 14221 occasionally to allow side-port access to assess catheter patency. This is a procedure that is considered of equivalent difficulty to item 14218 – refer to Recommendation 14.

4.2.5.1 Rationale 17

The item 14221 is currently being used for a variety of purposes across a number of areas, including oncology, haematology and pain management.

This recommendation focuses on effective use of the health system. It is based on the following assessment:

- The Committee determined that there may be an overuse of item 14221. The intended use of this item relates mainly to devices infusing into the venous system and its use is outside the remit and scope of the Committee.
- The Committee notes that some compliance modelling was completed in relation to item 14221 and its use for insulin pump uploads. Compliance determined that this use is inconsistent with the current descriptor as it uses the word 'implanted', which is intended for devices that are inserted into the body under the skin. Insulin pumps are not implanted.
- Item 14221 is used by oncology for the access of a chemotherapy device. There is no item for heparin locks that provide maintenance of patency, antibiotic administration or sampling of blood etc. The use of 14221 for these purposes appears to be inappropriate with the current descriptor of 14221.



- The Committee determined that it was not qualified to identify concerns regarding safety, access, value or contemporary best practice with the Oncology or infectious disease use of this item.
- Whilst reviewing item 13945 the Oncology Clinical Committee (OCC) recommended to *'remove item 13945 from the MBS, remove the reference to item 13945 from item 14221, and prevent use of item 14221 where the service is provided in conjunction with the administration of anticancer therapy. This recommendation recognises that use of long-term vascular access devices with anticancer therapy is part of the standard of care and does not represent a separate, distinct service. The recommendation also addresses highly irregular and variable patterns of use for item 13945 across providers, thereby improving value for the patient and the health system'*.
- Both the OCC and the Committee note there are additional aspects on the usage of item 14221 (outside of medical oncology or pain management) that warrant further investigation potentially as part of an ongoing review mechanism.
- Further review of this item would best take place in consultation with oncologists, haematologists, Specialist Pain Medicine Physicians, palliative care physicians and nurses.

4.2.6 Recommendation 18 – Better explanation of the use of implanted devices (Items set out in Table 5)

The Committee recommends:

- a. adding explanatory notes for all implanted device items considered by the Committee.

**New Explanatory Notes – Implanted device items.**

As with all interventions, implant procedures must be performed in the context of clinical best practice. This is of particular importance given the high cost of the devices. Current clinical best practice for use of these item numbers includes:

- All procedures being performed in the context of a comprehensive pain management approach with a multidisciplinary team.
- Patients must be appropriately selected for the procedure, including, but not limited to assessment of physical and psychological function prior to implantation with findings documented in the medical record.
- Outcome evaluation pre and post implantation.
- Appropriate follow up and ongoing management of implanted medical devices must be ensured.

Implantable devices require ongoing monitoring and management. If the person providing the implantation service is not the ongoing physician manager of the device, they are responsible for ensuring that appropriate ongoing management has been arranged.

- b. due to evolving evidence regarding what population groups benefit from these procedures, these item numbers should be reviewed in 2 years to ensure ongoing evidence based applicability.

4.2.6.1 Rationale 18

The pain management items of the MBS cover a wide variety of treatment options including implanted devices. The use of these devices is an area of ongoing development in effective practice.

This recommendation focuses on clarifying service provision best practice and effective use of the health system. It is based on the following assessment:

- Implantable devices may be an effective and cost effective pain management intervention in a very select patient population. There is a high risk of poor outcomes and lack of cost effectiveness with inadequate patient selection and follow up (International Neuromodulation Society, 2017). It is difficult to modify the descriptors to contain all the criteria needed for a good patient outcome and this is not generally included in a descriptor. In addition, evidence continues to evolve regarding patients who may benefit from these procedures.



- Clinical guidelines for implantable devices for pain management are currently under development by the Faculty of Pain Medicine and should be incorporated in the notes when available.
- It was considered that outlining high level best clinical practice in the explanatory notes would be helpful in guiding clinical practice and patient selection.
- Due to evolving evidence, it is recommended that these item numbers be reviewed in 2 years to ensure ongoing evidence-based applicability.

4.2.7 Recommendation 19 – Reflecting best practice in items 39130, 39134, 39135, 39136 and 39137 – use of assistants

The Committee recommends that items 39130, 39134, 39135, 39136 and 39137 be considered for use of an assistant fee to enable the procedure to be performed safely, noting that the assistant fee is currently being discussed by the Principles and Rules Committee for restructuring around the mechanisms for claiming.

4.2.7.1 Rationale 19

These items pertain to more complex procedures for the implantation of devices.

These procedures are considered to be two person procedures and there is a higher rate of complications when insertion is performed alone. Therefore, for safety reasons an assistant support item is recommended.



4.3 Surgical Co-claiming

Table 6: Surgical Co-claiming items considered by working group

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance	\$62.50	250	\$11,997	4.8
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)	\$189.90	34385	\$5,444,264	11.9
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)	\$124.85	13888	\$1,442,771	21.9
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)	\$62.50	47237	\$2,467,760	22.2
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies	\$37.65	406	\$13,202	3.7
18244	VAGUS NERVE, injection of an anaesthetic agent	\$100.80	428	\$34,084	53.5
18252	CERVICAL PLEXUS, injection of an anaesthetic agent	\$100.80	6159	\$470,355	19.9
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent	\$100.80	558	\$42,814	29.0
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)	\$62.50	13,319	\$658,079	13.0
18264	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent	\$100.80	33,571	\$2,614,048	18.2
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block	\$62.50	6648	\$323,641	25.3



Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18270	FEMORAL NERVE, injection of an anaesthetic agent	\$88.65	4,927	\$983,487	26.0
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	\$62.50	14,665	\$1,702,775	13.8
18278	SCIATIC NERVE, injection of an anaesthetic agent	\$88.65	400	\$28,169	9.3
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent	\$124.85	5,418	\$507,387	5.9
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)	\$147.65	158	\$18,105	7.1

4.3.1 Recommendation 20 – Restriction of co-claiming of items 18228, 18232, 18238, 18244, 18252, 18254, 18262, 18264, 18266, 18278, 18280 and 18288

The Committee recommends:

- these items should not be co-claimed with the surgical procedure if the nerve block is undertaken by field infiltration or under direct surgical exposure. Targeted percutaneous nerve blocks may still be co-claimed with the surgical procedure.
- the appropriate surgical committees be informed about the changes to these item numbers.
- amending the descriptors to include (changes in bold):

Items 18228, 18232, 18238, 18244, 18252, 18254, 18262, 18278, 18264, 18266, 18278, 18280 and 18288 Add:

‘not to be co-claimed with any surgical procedures, including those performed under local anaesthesia unless the nerve block involves a targeted percutaneous approach’.

Note: For item 18232 please refer to recommendation 4 for further recommendations.



4.3.1.1 Rationale 20

The pain management items of the MBS cover a wide variety of treatment options including pain treatment in conjunction with surgical procedures.

This recommendation focuses on clarifying service provision best practice and effective use of the health system. It is based on the following assessment:

- The Committee agreed from the co-claiming evidence that many of the pain management items under consideration are being inappropriately co-claimed with a surgical procedure. This is happening across different specialties and includes:
 - Claiming these items when field infiltration or a nerve block under open surgical exposure is a standard part of the procedure for either analgesia or immobilisation.
 - For example co-claiming nerve blocks when infiltration of local anaesthesia is used for procedures such as vasectomy, varicose sclerotherapy and removal of skin lesions where a targeted percutaneous nerve block is not appropriate.
- The Committee considers that this is unintended practice which goes against the spirit of the MBS and that the principle of providing 'complete medical services' should be encouraged where possible.
- There was broad agreement across the Committee that the pain management items should not be co-claimed when they are a standard part of the surgical procedure.
- The Committee noted that the data identifying co-claiming practices where pain management items were being claimed 80% of the time with the surgical procedure suggested that the analgesia was a requirement of the surgery and therefore should form part of a 'complete medical service'.

The Committee supports the retention of stand-alone items in cases where the items are used for chronic pain or cancer pain or, in limited cases, acute pain outside the operating theatre.

4.3.2 Recommendation 21 – Clarifying items 18234 and 18236 - trigeminal nerve

The Committee recommends that items 18234 and 18236 should not be co-claimed with any surgical procedures, including those performed under local anaesthesia unless the nerve block involves a targeted percutaneous approach. In addition items 18234 and 18236 should not be co-claimed with each other at the time of surgery and that the descriptor be amended to (changes in bold):

**Item 18234**

- TRIGEMINAL NERVE, primary branch (**ophthalmic, maxillary or mandibular branches**) injection of an anaesthetic agent or steroid (Anaes.). Should not be co-claimed **at the time of surgery unless a targeted percutaneous technique is used or at the time of surgery with 18236.**

and

Item 18236

TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent. Should not be co-claimed **at the time of surgery unless a targeted percutaneous technique is used or at the time of surgery with 18234.**

4.3.2.1 Rationale 21

Items 18234 and 18236 provide for treatment of the trigeminal nerve via primary division or peripheral branch injection of an anaesthetic agent respectively.

This recommendation focuses on clarifying service provision best practice and effective use of the health system. It is based on the following assessment:

- In nearly all identified situations, it is only appropriate to claim one of these item numbers.
- The Committee identified the possibility of a limited number of cases where there may be contributions to facial pain from both primary and peripheral trigeminal branches. In such cases both a primary and peripheral injection of anaesthetic agent may be warranted and 18234 could to be claimed with 18236.
- However, this number is thought to be very small and not applicable to surgical procedures.
- The data suggests that items 18234 and 18236 are being co-claimed approximately 15,535 times per year (16/17 year data).

4.3.3 Recommendation 22 – Future review item 18278 – sciatic nerve co-claiming

The Committee recommends that item 18278 requires future review.



4.3.3.1 Rationale 22

Item 18278 provides for treatment of the sciatic nerve by injection of an anaesthetic agent.

This recommendation focuses on ensuring continuing effective use of the health system into the future. It is based on the following assessment:

- The Committee identified that item 18278 appeared to be co-claimed with transfusion which the Committee hypothesised was the use of platelet rich plasma for knee pain.
- The use of platelet rich plasma for knee pain is not currently supported by an MBS item number.
- The Committee considered that this issue required further investigation and/or consideration to ensure correct claiming and appropriate MBS inclusion.



5. Recommendations for deletions and/or review

5.1 Deletions

Table 7: Items – Deletions

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)	\$88.65	63,985	\$4,816,805	13.6
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	\$124.85	18,668	\$1,888,203	9.8
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.)	\$75.30	67	\$4,190	-11.2

5.1.1 Recommendation 23 – Deletion of items 18274, , 39115 - outdated and not best practice

The Committee recommends the deletion of items 18274 and 39115.

5.1.1.1 Rationale 23

This recommendation focuses on ensuring continued effective use of the health system into the future. It is based on the following assessment:

- The Committee has determined that item 18274 is not necessary because a multi-level injection is required to block even a single facet joint (Kennedy, et al., 2018).
- The Committee notes that deletion of 18274 will result in an increase in fees associated with item 18276. The Committee considers that is justified because a multi-level injection is required to block even a single facet joint therefore though the item will technically be 'absorbed' by item 18276, the procedure is already



being performed in line with item 18276 and therefore should attract the equivalent fee.

- The Committee has determined that item 39115 is an historical number used for an outdated procedure and should be deleted as there are more appropriate pain management options available. This is supported by data that shows usage has continued to decrease by 42% over the 2016/17 to 2017/18 period.

5.2 Referrals to other clinical committees

Table 8: Items – Referrals to other clinical committees

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth %	Expected change in services due to recommendation
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent	\$62.50	435	\$21,925	-1.7	n/a
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent	\$88.65	4,719	\$320,622	16.4	n/a
18270	FEMORAL NERVE, injection of an anaesthetic agent	\$88.65	4,927	\$983,487	26.0	n/a
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	\$62.50	14,665	\$1,702,775	13.8	n/a
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure	\$100.80	28	\$2,139	25.5	n/a

5.2.1 Recommendation 24 – Referrals of items 18258, 18260, 18270, 18272 and 18282

The Committee recommends:

- items 18258 and 18260 be considered by the Thoracic Surgery Clinical Committee, with the advice on how specialist pain medicine physicians use these items, and
- items 18272, 18270 and 18282 be considered by the Vascular Clinical Committee.



5.2.1.1 Rationale 24

This recommendation focuses on ensuring continuing effective use of the health system into the future. It is based on the following assessment:

- Items 18258 and 18260 are not used in volume by Specialist Pain Medicine Physicians.
- Items 18258 and 18260 usage relates to chest trauma (e.g. rib fractures) and there is substantial use associated with thoracic surgery. The items are used by Specialist Pain Medicine Physicians as a diagnostic procedure in the palliative setting in determining whether to proceed to a neurolytic procedure or other intervention, however usage is higher in the thoracic surgery specialty.
- Items 18270 and 18272 are mostly used in the treatment of varicose veins, it is rarely used as a stand-alone item for the treatment of chronic pain.
- The Committee had concerns that a femoral nerve block performed properly would result in motor blockade (essentially a “dead leg”) so that this was not a suitable claim for outpatient procedures as the patient would be unable to ambulate to go home. The hypothesis is that these are being claimed for local infiltration not true femoral nerve block.
- Item 18282 is a low-use item not used by Specialist Pain Medicine Physicians but by vascular surgeons.



6. Recommendations for new items

6.1 Access to Botox for pelvic tension myalgia

Botulinum toxin (Botox) injections are used and recognised by the MBS in a wide range of medical conditions where muscle spasm is present, including migraine, cerebral palsy, torticollis, blepharospasm and detrusor overactivity (items 18350-18379).

6.1.1 Recommendation 25 - Botox for Pelvic Tension Myalgia (MSAC consideration)

The Committee recommends:

- a. a new item be considered by MSAC to be added to the MBS, as set out below:

New Item

- Botulinum toxin type A for reducing pain and pelvic floor pressure in women with chronic pelvic pain and pelvic floor muscle spasm.
- Botox injection for the treatment of moderate to severe focal spasticity if:
 - a. the patient is at least 18 years of age,
 - b. she is not pregnant,
 - c. the dysfunction is associated with muscle tension of the pelvic floor,
 - d. she has consulted a suitably qualified pelvic physiotherapist and standard treatment for the condition (physiotherapy to down-train muscles) has failed
or the treatment will aid physiotherapy.
- A lifetime limit of 4 injections supported under the MBS at intervals of no less than 6 months between injections
- The procedure is to be performed by an appropriately trained doctor.

6.1.1.1 Rationale 25

This recommendation focuses on ensuring improving value to the patient and instituting best practice. It is based on the following assessment:

- Pelvic pain is estimated to affect between 15% and 25% of women (Grace & Zondervan, 2004) (Mathias, Kupperman, Liberman, & et al, 1996). As with many types of persistent pain, muscle dysfunction may accompany persistent pelvic pain. Mild to moderate cases



can be managed effectively with a combination of pelvic physiotherapy to 'down-train' muscles, increased gentle exercise with avoidance of aggravating activities and the use of medications. However, where pain is severe, these treatment options may be impractical or inadequately effective.

- Botulinum toxin (Botox) injections are used and recognised by the MBS in a wide range of medical conditions where muscle spasm is present, including migraine, cerebral palsy, torticollis, blepharospasm and detrusor overactivity (items 18350-18379). Injections of Botox to pubococcygeus and obturator internus have been used in the management of the severe pain associated with pelvic muscle spasm with evidence of long term/short term effectiveness. (Grace & Zondervan, 2004) (Mathias, Kupperman, Liberman, & et al, 1996)
- For focal spasticity in adults and children two years and older BOTOX® treatment reduces both the objective signs and subjective symptoms of spasticity. Improvements include reduction in muscle tone, increase in range of motion, reduction in pain and a reduction of spasticity-related functional disability.
- Improvement in pelvic pain for people treated with this procedure / (or adequately treated for other types of severe pain) led to return to work, decreased use of strong analgesia, improved community participation and decreased use of health services etc. (Grace & Zondervan, 2004) (Mathias, Kupperman, Liberman, & et al, 1996) It is estimated that a small percentage of patients (potentially 10% of those who meet the criteria) (Grace & Zondervan, 2004) (Mathias, Kupperman, Liberman, & et al, 1996) would use Botox as a treatment option.
- Botox is listed for muscle spasticity on the Australian Register of Therapeutic Goods (ARTG).
- To ensure patient safety and effective treatment the procedure should be performed by an appropriately trained doctor.



7. Recommendations to improve access to evidence based care for people with chronic pain

7.1 Better access to evidence based care for people with chronic pain

In its current form, the MBS does not support multidisciplinary, patient-centred approaches to pain management at an adequate dose (number of visits). (The Australian Pain Society, 2017) (Healthcare Improvement Scotland, 2013) Best practice management for chronic non-cancer pain involves the understanding of and attention to physical, psychological and sociological factors associated with pain (Faculty of Pain Medicine, 2010). There is also a need for an effective multi-modal approach for at-risk individuals with acute pain to prevent progression to chronicity.

Effective treatment of chronic pain involves a long-term multidimensional management plan to equip the patient with self-management skills. (Australian Commission on Safety and Quality in Health Care, 2015) Often this requires multidisciplinary input. Self-management skills can be applied for as long as pain persists and may, in themselves, reduce pain intensity over time. Focusing on just one aspect of management (medications, physical therapy or psychological approaches) is unlikely to lead to optimal outcomes such as maximised daily function (Royal Australian College of General Practitioners, 2016).

Chronic pain is Australia's third most costly health condition after cardiovascular diseases and musculoskeletal conditions (also associated with chronic pain). The total financial cost of chronic pain in Australia in 2018 was estimated to be \$73.2 billion, including \$12.2 billion in health system costs, \$48.3 billion in productivity losses and \$12.7 billion in other financial costs, such as informal care, aids and modifications and deadweight losses. (Painaustralia, 2019)

The Department of Health has acknowledged the current deficiencies in treatment of chronic pain in the [National Strategic Action Plan for Pain Management](#) 2019. The National Strategic Action Plan for Pain Management 2019 was developed by Painaustralia with funding from the Australian Government Department of Health. The Pain Management Clinical Committee endorse the National Strategic Action Plan and have identified the following elements as being important to the MBS review and vital to effective chronic pain management in Australia:



- Access to multidisciplinary care outside of state services (Goal 4 NSAPPM)
- Carefully developed pain management plans (Goal 4.2 NSAPPM)
- Access to an evidence based number of visits to allied health (Goal 4.2 NSAPPM)
- Access to group therapy (Goal 4.3 NSAPPM)
- Access to pain management services via Telehealth (Goal 4.5 NSAPPM)

The Committee believes that these outcomes may be achieved through multiple different options. It is anticipated that the exact MBS mechanisms for the management of chronic pain will be considered in the deliberations of the Allied Health Reference Group and the General Practice Primary Care Clinical Committee in the context of current item numbers, changes occurring as part of the MBS review, current medical practice and Health department policy.

The Committee has listed multiple options that have the potential to meet these outcomes as outlined in the following sections. These seek to provide the foundations for a robust, effective and efficient approach to multidisciplinary care for chronic pain management via a variety of methods, including face-to-face and group meetings as well as telehealth technologies.

7.1.1 Recommendation 26 – Access to multidisciplinary pain management, pain management plans and an evidence based number of allied health visits

The Committee recommends the consideration of a combination of the following options:

- a. Modify the current Chronic Disease GP Management Plans and Team Care Arrangements (item numbers 229, 721, 230 and 723) to explicitly include chronic pain. AND/OR
- b. Create a new GP Chronic pain management plan item number AND/OR
- c. Build in a time and complexity tiered approach relating to the number of allied health visits able to be accessed to address the differing levels of need of patients

For each option:

- completion of a plan for chronic pain would allow eligible patients to access rebates for a number of relevant allied health visits
- A form of shared medical record must be used between members of the team for ongoing care of the chronic pain patient to facilitate communication with all members of the multidisciplinary team.



- a. modify the current Chronic Disease Items (items 132 and 133) to explicitly include chronic pain as a chronic disease and allow specialist pain medicine physicians access to development of the pain aspect of the plan AND/OR
- b. Introduce a multidisciplinary Chronic Pain Management Plan option for specialist Pain medicine physicians, similar to how Psychiatrists can develop a Psychiatric Assessment and Management Plan (item 291)

AND/OR

Build in a time and complexity tiered approach relating to the number of allied health visits able to be accessed by specialist pain medicine physician referral.

For each option:

- completion of a plan for chronic pain would allow eligible patients to access rebates for a number of relevant allied health visits.
- The Committee recognises the need to keep GPs as a key part of the treating team, and as such, the patients regular GP would always need to be one of the multidisciplinary team and have opportunity to input into the plan.
- A form of shared medical record must be used between members of the team for ongoing care of the chronic pain patient to facilitate communication with all members of the multidisciplinary team.

Introduce multidisciplinary initial assessment items for each member of the treating team

- a. Multidisciplinary Chronic Pain Management Plan review item,
AND/OR
- b. Access to case conferencing, available to each member of the treating team.

For all options:

- All participants should be trained in chronic pain management as determined by the relevant colleges or professional bodies.
- There must be specific communication between members of the pain management team regarding review of progress and recommended future needs.
 - The review mechanism could potentially unlock access to additional relevant allied health rebates if required.
 - Review may or may not require case conferencing - documented communication in a shared medical record between all members of the team regarding progress and future needs would be adequate.



7.1.1.1 Rationale for improving access to multidisciplinary care

These recommendations focus on ensuring improved patient care, collaboration between members of the health system, implementing best practice and continuing effective use of the health system. It is based on the following assessment:

- **Multidisciplinary care** (NSW Agency for Clinical Innovation, 2015): Access to multidisciplinary teams for assessment, participation in the development of a management plan, and review enables people with chronic pain to learn to self-manage, optimise medical therapy, and be supported through any required rehabilitation or retraining (cancer.org.au, n.d.). The ideal team will vary between individuals, determined by the severity and type of their pain, but may include health professionals from general practice, physiotherapy, psychology, exercise physiology, occupational therapy, and pharmacy along with specialist pain medicine physicians.
- **Chronic pain as a chronic disease:** Chronic pain is recognised as a chronic disease and, as such, it should be listed in MBS material that relates to chronic disease item numbers to prevent confusion. Current chronic disease items may be suitable for those who do not have other comorbidities and less complex pain management needs.
- **A separate Chronic Pain Management plan:** Many people who have chronic pain also have an additional chronic disease, such as diabetes. For these people, allied health visits available under GP chronic disease items are rapidly used in the management of the other chronic disease, leaving no allied health visits available for management of their chronic pain. A separate Chronic Pain Management plan would allow multidisciplinary management of both chronic pain and other comorbidities.
- **Better Access Initiative Mental Health framework as a model:** The GP mental health items (items 2700 to 2717) have provided a structured framework for GPs to undertake early intervention, assessment and management of patients with mental health disorders, as well as providing referral pathways to clinical psychologists, health psychologists, and appropriately trained social workers and occupational therapists. The Committee suggests that a multidisciplinary chronic pain management framework might be developed using the mental health framework as a model (items 2700 to 2717 and the supporting accreditation and training). This would put well trained GPs at the centre of chronic pain care and enable a patient with chronic pain greater access to allied health services, such as physiotherapy, psychology and occupational therapy services.



Brief, targeted mental health training under the mental health framework is used to help GPs further develop and improve their skills in diagnosing, treating and referring patients with mental disorders to appropriate services. Well developed short training in chronic pain management is likely to improve the skills of GPs in identifying the best options for treatment for an individual with chronic pain and improve knowledge of the multidisciplinary support available in their region. Incentivisation for undertaking the training should be considered.

- **Multidisciplinary input into the development of management plans:** Chronic pain management plans are best developed following multidisciplinary assessment and communication between the members of the treating team (cancer.org.au, n.d.). The introduction of initial assessment items that can be accessed by select allied health prior to the development of a Chronic Pain Management Plan will enable input from relevant team members to provide the most appropriately tailored plan.
- **Specialist pain medicine physician multidisciplinary care plans:** This would enable improved access to care for people with chronic pain who require specialist care who can currently only access this through overloaded state funded facilities.

It is important to include the GP in the treating team in a way that streamlines patient access to allied health, coordinates treatment of other medical conditions and supports all team members and the patient to be working toward the same goal. It is believed that requiring the patients regular GP to be part of the treatment team if a specialist has developed the plan will facilitate these outcomes as will a shared medical record.

- **Increased access to Allied health - appropriate treatment dose according to level of need:** Access to allied health through current chronic disease items is helpful but at an inadequate evidence based dose for most people with chronic pain.

Aligning the number of allied health visits with the evidence base for treatment will better recognise the complex nature of treating pain as part of a comprehensive assessment and treatment program. Patients with chronic pain who have mild to moderate levels of distress/disability should reliably respond to less than 10 sessions of targeted multidisciplinary pain self-management treatment. Patients with higher distress/disability will need more sessions.

If the case is recent onset (1-8 weeks) the low intensity programs (group or individual) should be sufficient (in the WISE study in NSW, five sessions, on average, with a psychologist, plus physio exercises were enough for sustained return to work, improved mood and function) (Australian Pain Society, n.d.).



High distress/disability cases will need more comprehensive and longer programs. More intensive interdisciplinary (The Australian Pain Society, 2017) programs (50-100 hrs over 3-5 weeks) have more reliable effects with high severity cases (Australian Pain Society, n.d.).

- **Increased access to allied health – direct referral from a specialist pain medicine physician in the context of a multidisciplinary team:** Effective chronic pain management involves a multi-modal approach to treatment including allied health (The Australian Pain Society, 2017).

Currently, specialists wishing to refer patients to allied health professionals and have them be eligible for MBS reimbursement must send the patient back to a GP, who may not be their regular GP, to ask for referral. This is an added financial and time barrier to the patient. This approach can result in untimely, under-treatment of individuals.

From a patient perspective it is often difficult, costly (to the patient and the healthcare system), unnecessary and often ineffective to be returning to a GP to obtain recommended allied health referrals when their time with that member of the treating team could be used more effectively.

- **Shared Medical Records:** Collaboration is a vital part of any management by a team of health care providers. Traditionally, pain management teams have been geographically co-located and state funded, which can provide well-coordinated and tailored care for patients. This model, however, is not always feasible for large scale patient access, in rural or remote areas or in private settings. If the treating team that deliver chronic pain management have some form of shared medical record, this will enable each member of the multidisciplinary team to tailor their response based on the needs of the patient and the relevant expertise available in the region/ by telehealth that may or may not be co-located with the treating doctor.
- **Review items:** Review of a case cannot always occur with all members of the treating team present on one occasion or with the patient present. Review items facilitate communication between team members which can take significant time and is currently not rebatable under the MBS.
- **Case conferencing:** Case conferencing allows members of the treating team to summarise progress, discuss issues that have arisen during their treatment that can be managed by other members of the team, and problem solve together. Case conferencing item numbers support multidisciplinary care for complex cases. Currently, case conferencing items are limited and either not applicable to the situation or many of the treating team are unable to access them.



Case conferencing items should be flexible enough to incorporate new technologies that allow team communication in ways beyond face to face or teleconferencing. Relying on all members of the team to meet face to face is often an insurmountable barrier when team members are not co-located.

Case conferencing items facilitate geographically separate multidisciplinary care. Traditionally, pain management teams have been geographically co-located and state funded, which can provide well-coordinated and tailored care for patients. This model, however, is not always feasible for large scale patient access or in rural or remote areas.

Estimate of need

- It is estimated that approximately 35,000 people would require access each year to these item numbers. Some of these people would currently be receiving care under the chronic disease management and team care arrangement items or better access for mental health items.



7.1.2 Recommendation 27: Access to group therapy for pain management

The Committee recommends:

A new MBS item be created covering provision of a chronic pain management health service provided to a person by an eligible clinician being a physiotherapist, nurse, exercise physiologist, clinical psychologist or occupational therapist with training and credentialing requirements to be determined by the relevant Colleges or peak bodies as a GROUP SERVICE if:

1. the service is provided to a person who is part of a group of between 4 and 12 patients inclusive; and
2. the person is not an admitted patient of a hospital; and
3. the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner or a specialist pain management physician); and
4. the service is provided to a person involving the personal attendance by the eligible clinician; and
5. the service is of at least 60 minutes duration; and
6. eligibility is limited to up to 10 sessions in a calendar year; and
7. after the last service in the group services program the eligible clinician prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
8. an attendance record for the group is maintained by the eligible clinician; and
9. in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

7.1.2.1 Rationale 27

This recommendation focuses on ensuring improved patient care, implementing best practice and continuing effective use of the health system. It is based on the following assessment:

- Intensive pain management group programs have the highest level of evidence of both benefit and efficiency in treating chronic pain, yet this is currently not



recognised under the MBS. This would decrease the cost to the individual and the health care system of procedures, medication and medical visits.

- Currently patients have difficulty accessing these services because of the limited number of available group pain programs in Australia (most are in public hospital settings).
- Medicare currently recognises the value of group treatment programs for psychiatry and diabetes education that are available to eligible people through items 80020 and 81100 to 81125.
- Tiered levels of access to group programs in accordance with need could be provided. The NSW guidelines (NSW Agency for Clinical Innovation, n.d.), which have been adopted as a national standard, provide a template for appropriate care.
- The Committee believes this recommendation to be relevant to several reviews across the MBS Review, including the Allied Health Reference Group and Chronic Disease Management Working Group.



8. Consumer impact statement

The key recommendations from a consumer perspective are summarised in this section of the Report. It aims to make it easier for the general public to better understand and comment on the report's recommendations.

Patients and clinicians are both expected to benefit from these recommendations. The recommendations address concerns regarding patient safety and quality of care, and they take steps to simplify the MBS and make it easier to use and understand. Patient access to services was considered for each recommendation. The Committee considered each recommendation's impact on provider groups to ensure that any changes were reasonable and fair. However, if the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.

Recommended changes to the pain management items covered in this report predominantly serve to improve the value of the services patients receive.

The Committee reviewed the 62 listed MBS items for pain management procedures and the report contains a detailed explanation of the specific changes that have been recommended. In particular, the Committee agreed that there is merit in revising MBS items where pain management items are being claimed alongside a surgical procedure. The Committee recommended removal of the ability to co-claim nerve blocks (for the diagnosis and management of chronic pain) with surgical items in keeping with the philosophy of a complete medical service. The Committee were of the view that, in most instances, the co-claiming of nerve blocks for the diagnosis and management of chronic pain alongside surgical procedure items went against the spirit of the MBS and that where a surgical procedure is being administered the scheduled fee should include the cost of any pain management incurred during the procedure.

The Committee has made a number of recommendations to amend item descriptors to prevent unintended claiming of incorrect items and ensure that item numbers accurately reflect the service being administered. Changes to explanatory notes have also been recommended to guide best practice use of implanted devices for the management of chronic pain.

In addition to recommendations relating to existing pain management MBS items, the Committee has also recommended that urgent consideration is given to the need for the



MBS to better reflect contemporary knowledge about persistent pain and evidence supporting the need for a biopsychosocial approach to managing this chronic condition, focussing on management and functional improvement, rather than treating the pain alone. This approach is recommended also in relation to cancer pain and to prevent the progression of acute pain to chronicity.

The Committee makes the point that a shift towards best practice, multidisciplinary pain management within the MBS would also reduce reliance on medications (including opioids) and expensive interventions. Equipping patients with the ability to self-manage their condition effectively, supported by allied health professionals, has the potential to reduce costs for both patients and government.

Accordingly, the report includes recommendations and presents a case for changes to the MBS to align with the best practice model of care. The Committee considered there was a case for:

- More appropriate rebates for specialist pain medicine physician consultations that establishes equity with other specialities.
- The ability for a specialist pain medicine physicians to order a Chronic Disease Care Plan for their patient, with referral to suitably trained allied health professionals (currently the MBS stipulates this can only be done by the GP which requires the patient to arrange a separate GP consultation. This is unhelpful to the patient, unnecessary, and adds to MBS and patient costs.)
- An increase in the number of allied health visits for eligible patients with chronic pain under the Chronic Disease Care Plan (currently 5 allied health visits). It is recommended that a Chronic Pain Care Plan which allows up to 10 visits to a physio, psychologist or other allied health professional, depending on the patient individual needs, would potentially achieve a better outcome, given the complex nature of chronic pain.
- New MBS items (rebates) to cover accredited pain programs – programs which enable the patient to better understand their condition and learn a range of strategies to support their ability to self-manage chronic pain.
- New MBS items that allow for multidisciplinary assessment and case conferencing for a multidisciplinary team caring for the patient with chronic pain.



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10. Glossary

Term	Description
ACT	Australian Capital Territory
Best Practice	Commercial or professional procedures that are accepted or prescribed as being correct or most effective.
Bier's Block	Intravenous regional anaesthesia (IVRA) or Bier block anaesthesia is an anaesthetic technique for surgical procedures on the body's extremities where a local anaesthetic is injected intravenously distal to a tourniquet.
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, "change" describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Chronic Intractable Pain (IP)	Pain that is excruciating, constant, incurable, and of such severity that it dominates virtually every conscious moment, produces mental and physical debilitation and may produce a desire to commit suicide for the sole purpose of stopping the pain.
Complete Medical Service	A service which provides holistic health care for the patient and their family/carer, which includes, prevention, and treatment for chronic and acute illnesses or disease
Clinical Committees	A committee which is chaired by a clinician practising in the area under review, and comprised of other clinicians, health system experts and consumers. General practitioners participate on all clinical reviews.
Clinician	A health care professional that works as a primary care giver of a patient in a hospital, skilled nursing facility, clinic, or patient's home. A clinician diagnoses and treats patients.
Consumer	People who use health services, as well as their family and carers
CHF	Consumer Health Forum
Diagnostic	Concerned with the diagnosis of illness or other problems



Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
Episode	A treatment or related multiple treatments administered by a physician during a single visit for a diagnosed condition.
FY	Financial year
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Implanted Devices	A medical device manufactured to replace a missing biological structure, support a damaged biological structure, or enhance an existing biological structure. Medical implants are man-made devices
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
MSAC	Medical Services Advisory Committee
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MBS	Medicare Benefits Schedule
MSAC	Medical Services Advisory Committee
Nerve Block(s)	The production of insensibility in a part of the body by injecting an anaesthetic close to the nerves that supply it.



Neurolytic Procedure	A technique requiring the administration of an agent that is capable of destroying neural structures involved in the perception of pain to promote long lasting analgesia (pain relief).
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Committee	Pain Management Clinical Committee
PBS	Pharmaceutical Benefits Scheme
Prioritisation matrix	Helps rank problems or issues (usually generated through brainstorming or other techniques) by a particular criterion that is important to the project
Principles & Rules Committee	A committee that considers the broader questions about the principles, objectives and boundaries shaping the MBS and its impact in practice
RACGP	Royal Australian College of General Practitioners
Rationale	A set of reasons or a logical basis for a course of action or belief.
Services average annual growth	The average growth per year, over five years to 2016/17, in utilisation of services. Also known as the compound annual growth rate (CAGR).
Spinal Injections	An injection into an area of the spine to help reduce pain and improve function through reducing inflammation (swelling and irritation) and/or nociception.
Stakeholder	Persons, groups or organisations that have an interest or concern in the outcomes of the MBS Review, and can affect or are affected by those outcomes.
Surgical Assistant(s)	An assistant to the surgeon who provides aid in exposure, haemostasis, closure, and other intraoperative technical functions that help the surgeon carry out a safe operation with optimal results for the patient.
Surgical Co-Claiming	Where an item is claimed in conjunction with a surgical procedure item which should form part of that surgical procedure.
The Committee	The Pain Management Clinical Committee of the MBS Review



The Taskforce	The MBS Review Taskforce
Therapeutic	The treatment of disease & and the action of remedial agents
Three-item rule	When more than three items are requested in an episode by a general practitioner for an out-of-hospital service, Medicare only pays for the three most expensive
Total benefits	Total benefits paid in 2016/17 unless otherwise specified.
Zygapophyseal	A set of synovial, plane joints between the articular processes of two (2) adjacent vertebrae.



Appendix A Summary for consumers

This table describes the medical service, the recommendations of the clinical experts and why the recommendations have been made.

Table 9: Summary for Consumers

Recommendation 1: *Clarifying item 18213 - intravenous regional anaesthesia*

Item	What it does	Committee recommendation	What would be different	Why
14209	Injection into the artery of an arm or leg with a particular medication	Deletion	Pain management specialists would no longer have access to this item. Claims would be made under item 18213	The item is no longer required as a stand-alone item for use by pain management specialists as current scientific evidence does not support the use of a sympatholytic agent
18213	Blocking the feeling in an arm or leg using an injection into a vein	The item be amended to allow for item 14209 to be incorporated	Claims for item 14209 would now be claimed under 18213.	It is more appropriate for pain management specialists to use item 18213



The item to read -
'Intraarterial infusion or
Intravenous regional
anaesthesia of limb by
retrograde perfusion'

This item remains as contemporary
clinical best practice and that the
change will clarify that other agents
are not supported by the evidence

Recommendation 2: *Clarifying items 18222 and 18225 - continuous infusion by catheter*

Item	What it does	Committee recommendation	What would be different	Why
18222	Giving medicine continuously to keep a part of the body from having feeling or pain, with the doctor there for 15 minutes or less	Amend item to include ' <i>not contrast medium</i> ' and ' <i>or injection continuous infusion by catheter</i> '	The item can no longer be used for diagnostic purposes	<p>The items should not be used for diagnostic purposes because adequate item numbers already exist for diagnostic radiology practice.</p> <p>Edits to the item ensures the use of these items are not for diagnostic purposes, improving the value of care provided by the MBS.</p>



18225	Giving medicine continuously to keep a part of the body from having feeling or pain with the doctor there for more than 15 minutes	Amend item descriptors to include ' <i>not contrast medium</i> ' and ' <i>or injection continuous infusion by catheter</i> '	The item can no longer be used for diagnostic purposes	The items should not be used for diagnostic purposes because adequate item numbers already exist for diagnostic radiology practice
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Recommendation 3: *Clarifying item 18230 - intrathecal or epidural injection of neurolytic substance*

Item	What it does	Committee recommendation	What would be different	Why
18230	Injection near the spinal cord of a substance that can damage nerves which is used to provide pain relief in chronic pain	Amend the item to 'INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (not contrast) by any route including transforaminal for the palliative treatment of chronic pain (Anaes.)'	The use of this item is not for diagnostic radiology procedures that use contrast	Amending the item will ensure the use is not for diagnostic procedures that use contrast Additional information in relation to route and treatment clarifies the item scope and encourages appropriate claiming

Recommendation 4: *Clarifying item 18232 - intrathecal or epidural injection of non-neurolytic substances*



Item	What it does	Committee recommendation	What would be different	Why
18232	Injection near the spinal cord of a substance that is not an anaesthetic (which causes numbness/stops feeling), contrast (which shows up on scans), or a substance that damages nerves which is used to diagnose a problem or provide pain relief in chronic pain	Expand to include epidural injection with local anaesthetic and steroid, specifically including the transforaminal route	Nothing, it is expected that claims are currently being claimed under this item.	Edits to the item are intended to provide clarity that services already being claimed are legitimate

Recommendation 5: *Clarifying item 18284 - ganglion*

Item	What it does	Committee recommendation	What would be different	Why
18284	Injection of an anaesthetic substance into the nerves at the bottom and side of the neck.	Amend to include to 'cervical or thoracic sympathetic chain injection of an anaesthetic agent'	Nothing, thoracic sympathetic chain blocks are currently being claimed under this item	Brings the local anaesthetic items into alignment with the neurolytic sympathetic chain blocks, providing clarity around claiming



This may reduce pain, swelling or sweating and may improve movement

Recommendation 6: *Clarifying item 18286 - pelvic sympathetic blocks*

Item	What it does	Committee recommendation	What would be different	Why
18286	<p>Injection of an anaesthetic substance into the nerves in the upper or lower back near the spine (thoracic or lumbar sympathetic chain).</p> <p>This may reduce pain, swelling or sweating and may improve movement</p>	Amend to exclude the thoracic region and include the pelvic region of the sympathetic chain	Nothing, pelvic sympathetic blocks are already claimed under this item	Limits any potential unintentional restriction on this item to areas above the pelvis and brings the local anaesthetic items into alignment with the neurolytic sympathetic chain blocks

Recommendation 7: *Reflecting best practice in items 18290 -18294 - neurolytic agent treatment*

Item	What it does	Committee recommendation	What would be different	Why
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18290	<p>Destruction of one of the nerves that come from the brain and go outside the skull to other parts of the body (the cranial nerves).</p> <p>This can be used to treat chronic pain. One of the nerves, the trigeminal, is not covered here.</p> <p>“Botox” injections are not covered by this item.</p>	Amend item to include ‘Under image guidance’.	Must now be performed under image guidance	Improves patient safety, and aligns the MBS to best practice
18292	<p>Destruction of one of the branches of nerves in the body.</p> <p>This can be used to treat chronic pain. “Botox” injections are not covered by this item.</p>	Amend item to include ‘Under image guidance’	Must now be performed under image guidance	Improves patient safety, and aligns the MBS to best practice
18294	<p>Destruction of a network of nerves (coeliac plexus) or particular nerves (splanchnic nerves) in the abdomen</p> <p>This may be done to treat chronic or cancer pain</p>	Amend item to include ‘Under image guidance’	Must now be performed under image guidance	Improves patient safety, and aligns the MBS to best practice



Recommendation 8: *Clarifying item 18296 - pelvic region of the sympathetic chain*

Item	What it does	Committee recommendation	What would be different	Why
18296	<p>Injection of an anaesthetic substance into a bundle of the nerves in the lower back near the spine (lumbar sympathetic chain)</p> <p>This may reduce pain, swelling or sweating and may improve movement</p>	Include reference to PELVIC region in item	Nothing, the PELVIC region is currently being claimed under this item.	<p>There is currently no item number which provides access to the pelvic region of the sympathetic chain for neurolytic injection.</p> <p>This change will reduce confusion with billing practices and will not change the number of claims per year</p>

Recommendation 9: *Reflecting best practice in item 39013 - intra-articular injection*

Item	What it does	Committee recommendation	What would be different	Why
39013	Injection of contrast (which shows up on a scan), anaesthetic (which makes	Delete 'or 1 or more primary posterior rami of spinal	Medial branch blocks will now be claimed under item 18276	There is currently widespread claiming of this item number for diagnostic medial branch blocks



it go numb), or corticosteroid (which reduces inflammation) into one or more of the small joints at the side of the spine (zygo-apophyseal joints or costo – transverse joints) or one the nerves that come out of the spinal cord (this description of the nerve pretty loose

nerves’ and ‘or costotransverse’.

Include ‘under image guidance’ and explanatory notes regarding longer lasting pain management techniques.

This item will only be available to intra-articular injection

Review in 2 years.

and the Committee considered that claiming for this procedure is better suited to item 18276.

Item will now be restricted to the lumbar region of the spine.

Recommendation 10: Clarifying item 39100 - trigeminal nerve

Item	What it does	Committee recommendation	What would be different	Why
39100	Injection of the nerve that is responsible for feeling in the face, and the muscles used for biting and	Amend to include that the injection should occur under image guidance and to	The procedure must be performed under image guidance	Clarifies what is considered as the ‘primary branch’ of the trigeminal



chewing (the trigeminal nerve), with a substance that will damage the nerve (alcohol or phenol) or a substance that will decrease inflammation (cortisone)	identify the three specific branches	nerve as there are three major branches
This is done to treat chronic pain		Adding 'under image guidance' improves safety for patients

Recommendation 11: Clarifying item 39118 - percutaneous neurotomy

Item	What it does	Committee recommendation	What would be different	Why
39118	Using radiowaves or freezing directed through needles in the skin to temporarily block the nerves that go to one of the small joints at the side of the spine (facet joints). A scan is done at the same time to guide the procedure. This is used to treat chronic or cancer pain.	Remove assistant fees associated with this item Create (6) new items for spine regions and sides of the body Restrict to three episodes per year for each region of the spine and side of the body	All new items will be created in order to restrict the level of services able to be performed in a 12 month period to left and right sides of the body, and spinal region (Cervical, Thoracic, Lumbar and Sacral).	The surgical three-item rule is designed to encourage procedures are performed over multiple days, therefore restricting claiming for this procedure to four procedures in a calendar year for a specified pain region will encourage quality patient experience and safety and ensure that the MBS aligns with best practice professional standards



Change wording from 'facet' to 'zygapophyseal' joint to achieve consistent wording with item 39013

Review in 2 years.

There is little evidence to support that pulsed radio-frequency is of lasting benefit for medial branch radio-frequency

The Committee does not believe that an assistant is needed for this procedure and patient safety will be maintained without it.

Recommendation 12: *Reflecting best practice in item 39323 - percutaneous neurotomy*

Item	What it does	Committee recommendation	What would be different	Why
39323	Using radio waves or freezing directed through the needles in the skin to temporarily block nerves A scan is done at the same time to guide the procedure. This is used to treat chronic or cancer pain	Limit number of repeat procedures to six procedures in a calendar year for a specified pain region Exclude 'medial branch nerve' Remove assistant fee.	Will only be claimable to a maximum of 6 episodes per year An assistant will not be allowed to be claimed as part of this procedure	Restrictions on episodes are for patient safety It is not considered necessary that an assistant is needed for this procedure


Recommendation 13: Clarifying item 14218 - infusion pump refilling

Item	What it does	Committee recommendation	What would be different	Why
14218	Refilling the (long term) pump that sits under the skin and delivers medicine to the spinal cord to control chronic or cancer pain	Removing 'epidural' and including 'including cancer related pain' Inclusion of "accessing the side port"	Accessing the side port can now be claimed under this item rather than item 14221	The amended item is intended to provide clarity around claiming practices and appropriate use of items Side-port access is considered equivalent difficulty to item 14218 therefore claiming will move from item 14221 to this item

Recommendation 14: Clarifying items 39125 to 39128 and item 39323 - infusion pump

Item	What it does	Committee recommendation	What would be different	Why
39125, 39126, 39127,	Placing a small, thin tube near the spinal cord that carries medicine from a pump under the skin to that area to control chronic and cancer pain.	The items be amended to include 'including cancer related pain'	Nothing, cancer related pain is not currently excluded by, although there is confusion	The amended items are intended to provide clarity around claiming practices and appropriate use of the items



39128, 39133	<p>Placing the pump under the skin that can deliver the medicine AND placing a small, thin tube near the spinal cord that carries medicine from the pump AND filling the pump</p> <p>Used to control chronic and cancer pain</p> <p>Removal of a pump under the skin or the removal or repositioning of the connected small thin tube that delivers medicine to the spinal cord to treat pain</p>	<p>in some minds about if they are applicable.</p>
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Recommendation 15: *Clarifying items 39131, 39134, 39135, 39136, 39137 and 39139 - neurostimulator*

Item	What it does	Committee recommendation	What would be different	Why
39131	Adjustment or reprogramming of mild electrical stimulator placed in the epidural or peripheral nerve space	Delete 'neuropathic' and 'intractable'	Removes restriction of the procedure to only the chest region	The amended items are intended to provide clarity around claiming



practices and appropriate use of the item number.

39134

Placement of mild electrical stimulator or receiver under the skin

Delete 'neuropathic' and 'intractable'

Removes restriction of the procedure to only the chest region

The amended items are intended to provide clarity around claiming practices and appropriate use of the item numbers

39135

Removing of mild electrical stimulator in operating theatres

Delete 'neuropathic' and 'intractable'.

Add 'open surgical removal'

Removes restriction of the procedure to only the chest region

Prevents the item from being inappropriately claimed when removing or repositioning leads percutaneously

Adding 'open surgical removal' or 'open surgical repositioning' is designed to prevent the item being inappropriately claimed when removing or repositioning leads percutaneously

39136

Removing of lead from the epidural or peripheral nerve space in an operating theatre

Delete 'neuropathic' and 'intractable'

Add 'open surgical removal'

Replace 'inserted' with 'implanted'

Removes restriction of the procedure to only the chest region

Prevents the item from being inappropriately claimed when removing or

Adding 'open surgical removal' or 'open surgical repositioning' is designed to prevent the item being inappropriately claimed when removing or repositioning leads percutaneously



			repositioning leads percutaneously	
39137	Repositioning of lead including intraoperative test stimulation.	Delete 'neuropathic' and 'intractable' Replace 'inserted' with 'implanted' Amend to include 'open surgical repositioning'	Removes restriction of the procedure to only the chest region Prevents the item from being inappropriately claimed when removing or repositioning leads percutaneously	Adding 'open surgical removal' or 'open surgical repositioning' is designed to prevent the item being inappropriately claimed when removing or repositioning leads percutaneously
39139	Placement of an epidural lead through the back of the vertebrae, including test stimulation.	Delete 'neuropathic' and 'intractable' Amend 'refractory angina pectoris' to 'refractory ischaemic pain'	Removes restriction of the procedure to only the chest region	Focuses on modernising the MBS and ensuring that high-value services are rebated The amended item is intended to provide clarity around claiming practices and appropriate use of the item numbers

Recommendation 16: *Clarifying items 39130 and 39138 – small electrical stimulation*



Item	What it does	Committee recommendation	What would be different	Why
39130	These items refer to Percutaneous	Deleting 'neuropathic'	There would no longer be a	The three item rule currently being
39138	Electrical Nerve Stimulation (PENS) therapy	Amend 'refractory angina pectoris' to 'refractory ischaemic pain'	4-lead restriction on the items	considered at the Principles and Rules Committee will supersede the 'maximum of 4 leads' rule
	Through the skin, putting a small lead near the spine that can deliver a small electrical stimulation to the area. Used in ion the treatment of chronic pain.	Deleting 'to a maximum of four leads'	Removes restriction of the procedure to only the chest region	To restrict the item being inappropriately claimed.
	Using a cut in the skin, putting a small lead near a nerve that can deliver a small electrical stimulation. Used in the treatment of chronic pain.	For item 39138 adding 'where the leads are intended to remain in situ long term'	Item 39138 restrict the item being inappropriately claimed, e.g. for Percutaneous Electrical Nerve Stimulation procedure (placement of an electrode for 20-30 mins with pulsed therapy delivered and then leads removed)	
		Adding explanatory notes to restrict use to appropriately trained practitioners		



Recommendation 17: Further review of item 14221 - devices infusing into the venous system

Item	What it does	Committee recommendation	What would be different	Why
14221	Accessing of a long-term implanted device for the delivery of therapeutic agents	Refer for review	N/A	Further evidence as to the use of this item is required to ensure it is being correctly used

Recommendation 18: Better explanation of the use of implanted device items

Item	What it does	Committee recommendation	What would be different	Why
All Implanted Device items	Various	<p>Better explanation to cover:</p> <p>Implant procedures should be performed in the context of clinical best practice. Current clinical best practice for use of these item numbers includes:</p>	<p>Outlining high level best clinical practice in the notes would be helpful in guiding clinical practice and patient selection.</p>	Ensuring that high-value services are performed safely and adequately by appropriate professionals



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- All procedures being performed in the context of a comprehensive pain management program with an appropriately qualified team.
 - Patients should be appropriately selected for the procedure, incorporating assessment of physical and psychological function prior to implantation with findings documented in medical record.
 - Outcome evaluation using validated measures pre and post implantation.
 - Ensuring appropriate follow up and ongoing management of implanted medical devices.
 - Implantable devices require ongoing monitoring and management. If the person providing the implantation service is not the ongoing physician manager of the device, they are responsible for ensuring that ongoing
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management has been arranged by an adequately trained professional.

- The Committee also recommends adding reference to the Faculty of Pain Medicine guidelines (currently starting development) when available.

Recommendation 19 – Reflecting best practice in items 39130, 39134, 39135, 39136 and 39137 – use of assistants

Item	What it does	Committee recommendation	What would be different	Why
39130, 39134, 39135, 39136, 39137	Placement, repositioning or removal of neurostimulators, leads or receivers that were inserted for pain treatment.	The items be considered for use of an assistant fee, noting that the assistant fee is currently being discussed by the Principles and Rules Committee for restructuring around the mechanisms of claiming	An assistant would be claimable under the MBS for these procedures.	<p>These procedures are considered to be two person procedures and there is a higher rate of complications when insertion is performed alone.</p> <p>Therefore for safety reasons an assistant support item is recommended</p>



Recommendation 20: Restriction of items 18228, 18232, 18238, 18244, 18252, 18254, 18262, 18264, 18266, 18280 and 18288 - diagnosis and management of chronic pain

Item	What it does	Committee recommendation	What would be different	Why
18228, 18232, 18238, 18244, 18252, 18256, 18262, 18264, 18266, 18280, 18288.	Various	<p>These items should not be co-claimed with a surgical procedure and restricted for use in the diagnosis and management of chronic pain</p> <p>Amended to add 'for the diagnosis or treatment of chronic pain or cancer pain'</p> <p>For item 18228, this should also include the management of acute chest wall injury (e.g. rib fractures)</p> <p>For item 18264, this should also include the management of acute pain related to labour/delivery</p>	These items will not be able to be co-claimed with a surgical procedure	<p>Many of the pain management items under consideration are being inappropriately co-claimed with a surgical procedure.</p> <p>The Committee believes that this is an unethical practice which goes against the spirit of the MBS and that the principle of providing 'complete medical services' should be encouraged where possible</p> <p>The pain management items should not be co-claimed with a surgical procedure when intraoperative analgesia should</p>



be an integral part of the surgical procedure

Recommendation 21: *Clarifying items 18234 and 18236 - trigeminal nerve*

Item	What it does	Committee recommendation	What would be different	Why
18234 18236	Injection of anaesthetic into primary and peripheral branches of the trigeminal nerve.	These two items cannot be co-claimed with each other These items cannot be co-claimed with any surgical procedure.	These two items can no longer be claimed together or with a surgical procedure	In nearly all identified situations, it is only appropriate to claim one of the item numbers, and generally these items should be claimed as part of the surgical procedure. (see complete medical service definition)

Recommendation 22: *Future review item 18278 – sciatic nerve co-claiming*

Item	What it does	Committee recommendation	What would be different	Why
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18278	Treatment of the sciatic nerve by injection of anaesthetic agent	Identified as requiring further future review	N/A	Further investigation is required to ensure correct claiming
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Recommendation 23: *Deletion of items 18274, 18276 and 39115 - outdated and not best practice*

Item	What it does	Committee recommendation	What would be different	Why
18274	Injection of a single nerve that comes out of the spinal cord to make it go numb.	Delete as it refers to outdated procedures and is no longer used for pain management	This item will no longer be able to be used	This is not necessary because a multi-level injection is required to block even a single facet joint
39115	Temporarily blocking/interrupting by any method the nerves that come out of the spinal cord	Delete as it refers to outdated procedures and is no longer used for pain management	This item will no longer be able to be used	<p>This item is very rarely used, with a decrease of 42% between 2016/2017 and 2017-2018</p> <p>This item is a historical number used for an outdated procedure and should be deleted to modernise the MBS</p>

**Recommendation 24: Referrals of items 18258, 18260, 18270, 18272 and 18282**

Item	What it does	Committee recommendation	What would be different	Why
18258, 18260, 18270, 18272, 18282	Various	Referral to other clinical committees.	N/A	These items are not used in volume by Pain Medicine Specialists, therefore the committee has referred these items to the Vascular Clinical Committee and the Thoracic Surgery Clinical Committees.