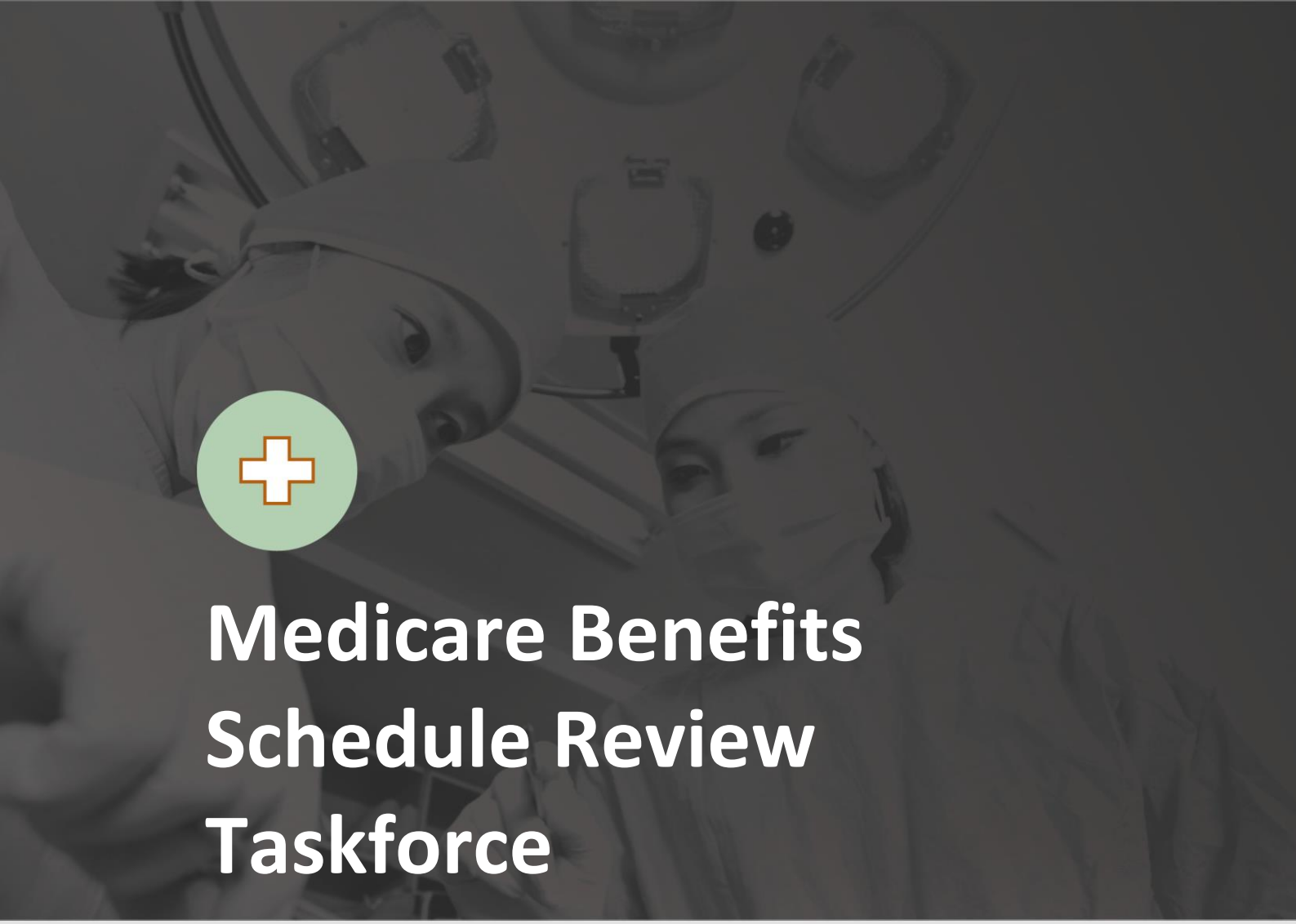

Medicare Benefits Schedule Review Taskforce

Final Report on the review of Colorectal Surgery MBS items

2019

IMPORTANT NOTES

1. This report does not constitute the final position on these items, which is subject to:
   - consideration by the Minister for Health, and
   - the Government.
2. The views and recommendations in this report originated from the clinical committee. Following consultation with stakeholders, the clinical committee made amendments and presented this report to the MBS Review Taskforce for its consideration.
3. Any eliminations, amendments or commentary from the MBS Review Taskforce are noted in boxed comments in the body of the report.

[Group] Recommendation [#] – Taskforce's Advice
[The Taskforce's rationale behind their decision.]

Original recommendation	Updated recommendation
Recommendation 23 Amend the item descriptor for item 32117 to read: "Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which items 32025, 32026 applies (Anaes.) (Assist.)"	The Taskforce endorses this recommendation and additionally recommends that the schedule fee for item 32117 be increased to $1,256.20. A rationale for this recommendation is provided within the annotation box at Recommendation 23 of this Report.
Recommendation 25 Create a new item for the repair of rectal prolapse using ventral rectopexy.	The Taskforce endorses this recommendation and additionally recommends that the proposed schedule fee for new item 320LL should be $1,256.20. A rationale for this recommendation is provided within the

	annotation box at Recommendation 25 of this Report.
Recommendation 39 Create twelve new items number for pelvic exenteration based upon the extensiveness of the procedure.	The Taskforce endorses this recommendation on the basis that the proposed fees are considered to be indicative values only. Further information is provided within the annotation box at Recommendation 39 of this Report.

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1. Executive summary

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.

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

The recommendations from the clinical committees are released for stakeholder consultation. The clinical committees consider feedback from stakeholders then provides recommendations to the Taskforce in a Review Report. The Taskforce considers the Review Reports from clinical committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

1.1. Key recommendations

The Committee reviewed 85 colorectal surgery items. The key recommendations from the Committee include:

- Highlighting three key issues in the care of colorectal surgery patients which the Committee identified as requiring further consideration across the MBS:
    - Access to stomal therapy nurses.

  - The use of enhanced recover after surgery (ERAS) principles.
  - Consumer health literacy.

- Amending the item descriptors of 24 items to accurately reflect current clinical practice and improve the definitions within these descriptors.
- Deleting 13 items that are clinically obsolete or describe procedures that are adequately encompassed in other colorectal surgery items.
- Combining similar procedures that are currently separated where there is no clinical reason to have separate items.
- Creating 22 new items for procedures that are currently being performed in practice, but are not as yet listed on the MBS. These are procedures which have evidence supporting their use and are increasingly considered best clinical practice. The new items include:
  - Seven new items for transanal total mesorectal excision (taTME); a standard surgical treatment for rectal cancer performed simultaneously by two surgeons/surgical teams.
  - One new item for ventral rectopexy; the preferred treatment for external rectal prolapse or symptomatic high grade internal prolapse.
  - Two new items for peritonectomy including hyperthermic intraperitoneal chemotherapy (HIPEC); surgical treatment to remove peritoneal mitotic disease.
  - Twelve new items for pelvic exenterations.

1.2. Consumer impact

All recommendations have been summarised for consumers in Appendix A – Summary for Consumers. The summary describes the medical service, the recommendation of the clinical experts, the rationale behind the recommendations and the changes for consumers. A full consumer impact statement is available in Section 5.

The Committee believes it is important to learn from consumers whether they will be helped or disadvantaged by the recommendations – and how, and why. Following public

consultation, the Committee will assess the advice from consumers in order to ensure all the important concerns are addressed. The Taskforce will then provide the recommendations to Government.

Both patients and providers 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.

The recommendations included in this report seek to simplify and streamline the portion of the MBS relating to colorectal surgery items. These recommendations are aimed at ensuring MBS items for colorectal surgical services accurately reflect current best practice and modern techniques for the surgical management of conditions affecting the colon and rectum. Recommendations described in the sections below have been developed to improve access to MBS-funded colorectal surgical services for those Australians who are likely to benefit most from them.

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 that 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 that 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 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 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 these 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-serviced.

- **Best practice health services**—one of the core objectives of the 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 Review is to have an MBS that supports 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 MBS 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 (1). 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 misused[2] 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 the Review Report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each clinical committee has to develop a work

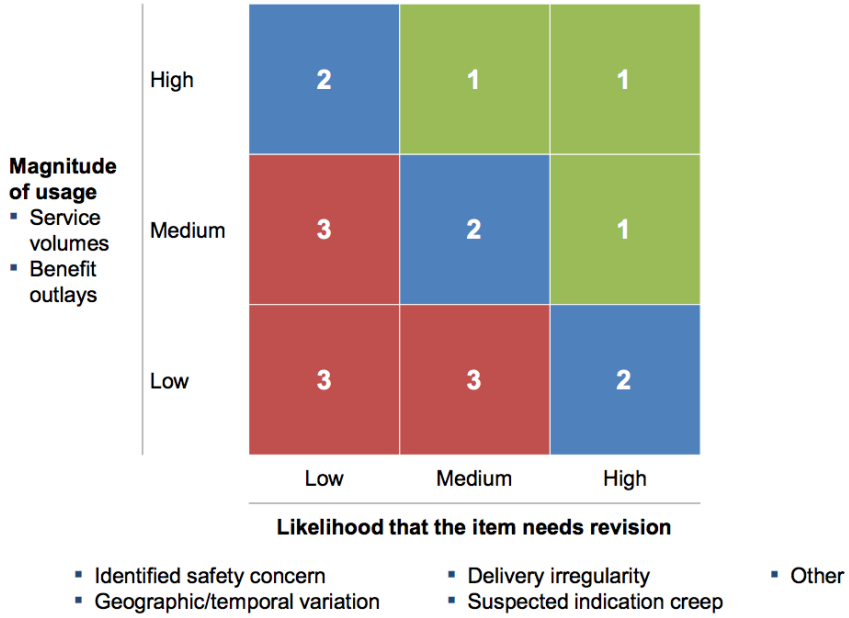
[1] The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

[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.

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:

- 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).

Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

2.5. The Complete Medical Service concept

The Taskforce has recommended that each MBS item in the surgical section (T8) of the MBS represents a complete medical service and highlighted that it is not appropriate to claim

additional items in relation to a procedure that are intrinsic to the performance of that procedure.

The Taskforce's rationale for making this recommendation is that 94 per cent of MBS benefits paid are for episodes where three or fewer items are claimed. On the occasions when more than three items are claimed in a single procedure or episode of care, there is often less transparency and greater inter-provider variability in benefits claimed for the same services, greater out-of-pocket expenditure for patients, and increased MBS expenditure that does not necessarily result in improved patient care.

Where the same group of three or more items are consistently co-claimed across providers, these represent a complete medical service and should be consolidated. Consolidation will improve consistency and optimise the quality of patient care; reduce unnecessary out-of-pocket costs for patients; and better correlate MBS expenditures with the actual services provided to patients.

3. About the Colorectal Surgery Clinical Committee

The Committee was established in 2018 to make recommendations to the Taskforce on the review of MBS items within its remit, based on rapid evidence review and clinical expertise.

3.1. Colorectal Surgery Clinical Committee members

The Committee consists of 14 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Colorectal Surgery Clinical Committee members

Name	Position/organisation	Declared conflict of interest
Associate Professor Andrew Stevenson (Chair)	Head of Colorectal Surgery, Royal Brisbane Hospital; Colorectal Surgeon, Holy Spirit Northside Hospital, Associate Professor of Colorectal Surgery, University of Queensland	User of MBS services Provider of MBS services Has received honoraria or worked as a proctor or consultant to a number of medical device companies that produce equipment used in laparoscopic or robotic surgeries (*Applied Medical, Intuitive Surgical , Johnson & Johnson, Medtronic, Olympus*)
Professor Michael Besser	MBS Review Taskforce ex-officio	User of MBS services
Associate Professor Chris Byrne	Colorectal Surgeon, Royal Prince Alfred Hospital, The Mater Hospital, North Sydney and Sydney Day Surgery; Clinical Associate Professor, University of Sydney School of Medicine, Honorary Treasurer, Colorectal Surgical Society Australia and New Zealand Executive Council	User of MBS services Provider of MBS services Councillor, Colorectal Surgical Society of Australia and New Zealand
Dr Nuwan Dharmaratne	General Practitioner	User of MBS services Provider of MBS services

Professor Alexander Heriot	Colorectal Surgeon, Epworth Freemasons Clarendon Street Hospital, Epworth Richmond Hospital; Clinical Director, Cancer Surgery Peter MacCullum Cancer Centre; Clinical Professorial Fellow, University of Melbourne; Chair of the Operations Committee of the Binational Colorectal Cancer Audit.	User of MBS services Provider of MBS services Physician Proctor, Johnson & Johnson, Medtronic.
Ms Rebecca James	MBS Review Taskforce Consumer ex-officio	User of MBS services
Ms Alison Marcus	Consumer	User of MBS services Former Registered Nurse and Stomal Therapy Nurse
Dr Elizabeth Murphy	Colorectal Surgeon, Head of Colorectal Unit, Lyell McEwin Hospital; Calvary North Adelaide Hospital, Calvary Central Districts Hospital and Ashford Hospital Councillor, Colorectal Surgical Society Australia and New Zealand Executive Council	User of MBS services Provider of MBS services Councillor, Colorectal Surgery Society of Australia and New Zealand Physician Proctor, Medtronic
Ms Sarah O'Shannassy	Colorectal Nurse and Advanced GI Surgical Program Manager, Royal Prince Alfred Hospital	User of MBS services Provider of MBS services Member, Australian Association of Stomal Therapy Nurses.
Professor Paul Pavli	Gastroenterologist, Staff Specialist Gastroenterology Unit, Canberra Hospital	User of MBS services Provider of MBS services Board member, Gastroenterological Society of Australia
Ms Geraldine Robertson	Consumer	User of MBS services
Associate Professor Margaret Schnitzler	Colorectal Surgeon, Royal North Shore Hospital, North Shore Private Hospital, Mater Misericordiae Hospital; Associate Professor, University of Sydney, Sub-Dean for Surgery and Academic Coordinator for Surgery, Northern Clinical School, University of Sydney	User of MBS services Provider of MBS services

Dr Vida Viliunas	Anaesthetist; Lecturer, Australian National University	User of MBS services Provider of MBS services Chair, Education Committee, Australian Society of Anaesthetist
Dr Michael Warner	Colorectal Surgeon, Hollywood Private Hospital and Sir Charles Gairdner Hospital. Member of Colorectal Surgical Society of Australia and New Zealand.	User of MBS services Provider of MBS services

Additionally, two Committee members declared themselves to have a personal medical history of colorectal cancer.

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 periodically. 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.

3.3. Areas of responsibility of the Committee

Colorectal surgery refers specifically to surgery of the colon and rectum (large intestine). This has historically been considered a component of general surgery. Increasingly colorectal surgery has become a field of subspecialty surgical management due to an increasing knowledge base - particularly for complex lower intestinal problems – increased training for minimally-invasive approaches (typically a further two years or more) and greater emphasis on careful anatomical dissection along embryological planes to achieve better patient outcomes.

The Committee reviewed 85 colorectal surgical MBS items. In the financial year 2016/17 these items accounted for approximately 82,000 services and $19 million in benefits. During

the past five years, service volumes for these items have grown by 1.6% and total cost of benefits paid has increased by 2.3%. This is largely in line with population growth which has increased by 1.6% for this period.

The MBS items reviewed by the Committee are shown in Table 2, below:

Table 2: MBS item numbers reviewed by the Committee, by classification.

Classification	No.	Item Numbers
Hemicolectomy, total colectomy and rectal resection items	14	32000, 32003, 32004, 32005, 32006, 32009, 32012, 32015, 32024, 32025, 32026, 32028, 32030, 32033
Synchronous surgeries	9	32018, 32021, 32042, 32045, 32046, 32054, 32057, 32063, 32066
Abdominoperineal resections	1	32039
Proctocolectomy and ileal pouch	3	32051, 32060, 32069
Rectal tumours	8	32096, 32099, 32102, 32103, 32104, 32105, 32106, 32108
Rectal prolapse	10	32111, 32112, 32114, 32115, 32117, 32120, 32123, 32126, 32129, 32131
Haemorrhoids, fistulae and abscesses	19	32132, 32135, 32138, 32139, 32142, 32145, 32147, 32150, 32153, 32156, 32159, 32162, 32165, 32166, 32168, 32174, 32175, 32177, 32180
Graciloplasty	4	32200, 32203, 32206, 32209
Sacral nerve leads	7	32210, 32213, 32214, 32215, 32216, 32217, 32218
Diagnostic	1	11833
Other colorectal items	9	32029, 32036, 32047, 32171, 32183, 32186, 32212, 32220, 32221

3.4. Summary of the Committee's review approach

The Committee completed a review of its items across four full committee meetings. These included two face-to-face meetings, two meetings via videoconference and three specialist subgroup videoconferences, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, 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 provider 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.

The Committee noted feedback provided by stakeholders which informed the final recommendations from the Committee. The Taskforce considered the report and stakeholder feedback before making recommendations to the Minister for Health for consideration by the Government.

4. Recommendations

The Committee reviewed 85 assigned colorectal surgery items and made recommendations based on evidence and clinical expertise, in consultation with relevant stakeholders. The item-level recommendations are described below. A consumer summary in table form can be found in Appendix A.

The Committee's recommendations are that:

- 13 items should be deleted from the MBS;
- 24 items should be amended and/or have fees adjusted;
- 15 items should be combined into 7 items
- 33 items should remain unchanged;
- 22 new items should be created for services not currently reflected by the MBS.

The changes focus on encouraging best practice, modernising the MBS to reflect contemporary best practice, and ensuring that MBS services provide value for the patient and the healthcare system. Some of this can be achieved by:

- deleting items that are obsolete;
- consolidating or splitting items to reflect contemporary practice;
- modernising item descriptors to reflect best practice; and
- providing clinical guidance for appropriate use through explanatory notes.

The Committee also considered three non-item level recommendations that span across a range of colorectal surgery MBS items. These relate to issues identified as integral to the optimal care of colorectal surgery patients. These include:

- Access to stomal therapy nursing;
- Enhanced recovery after surgery (ERAS); and
- Consumer health literacy.

These recommendations are detailed in Section 4.1, Section 4.2 and Section 4.3, respectively.

Non-item level recommendations

4.1 Access to Stomal Therapy Nurses

A stoma is constructed by bringing a portion of everted intestine with its blood supply to the exterior of the abdomen. Urinary stomas have the renal ureters secured to the portion of intestine. Faecal stomas can begin at various stages in the colon and may be loop or terminal-type stomas. The urine or faeces is collected in stomal appliance bags that are secured to the skin with compatible adhesive backing, with a range of other specialised products supplied through the Stoma Appliance Scheme also being required. A stoma may be required for conditions such as colorectal, urological or gynaecological cancer, Crohn's disease and other inflammatory bowel diseases, in cases of intractable faecal incontinence and in some congenital conditions (colostomy, ileostomy, or urostomy).

A stoma may be temporary or permanent, with both requiring new skills to be learnt and physical, social and emotional adjustments to be made. Stomal Therapy Nurses have undertaken specialist education and training to help patients manage these changes.

There is wide disparity in patient access to stomal therapy nursing services across Australia. It can be more difficult for private hospital patients and for patients in regional and remote areas to access stomal therapy services, particularly following discharge from hospital. Access to services is further impaired by a shortage of nurses with sufficient stomal therapy qualifications. This can compromise appropriate care for patients who have had ostomy surgery and impact on the patient's physical, social and emotional outcomes.

Timely access to stomal therapy nursing services can greatly assist patients who will undergo elective or emergency colorectal or urinary diversion. Preoperative consultations can help in establishing optimal placement of the stoma, considering body habitus and the patient's capacities. Stomal therapy nursing services result in shorter hospital stays and decreased readmissions arising from complications of product adhesion, wound breakdown or the understandable anxiety as a result of a significant change in bodily function.

Recommendations

- That the Explanatory Notes for items 32025, 32026 and 32028 be amended to state that these procedures should be performed in a setting with adequate access to stomal therapy nurse services.

- Consider creating new items for services provided by stomal therapy nurses, who deliver specialised care for patients with a stoma. Services that are currently provided by stomal therapy nurses include management of faecal or urinary diversions, management of wounds, fistulae, and gastronomies, continence advice and pre and post-operative counselling.
- That the Government considers what additional steps could be taken to ensure that the extent and nature of the work performed by stomal therapy nurses is captured by the MBS. The Committee acknowledges that this is a complex policy space that warrants detailed consideration.

Rationale

The recommendations focus on improving access to care and are based on the following observations (2) (3) (4) (5) (6) (7):

- The Committee noted that stomal therapy nurses play an important role in the provision of care for patients living with either a temporary or permanent stoma. A stoma is often created during bowel surgery due to conditions such as colorectal, urological or gynaecological cancer, Crohn's disease and other inflammatory bowel diseases, or may be created due to trauma to the abdomen, congenital abnormalities, neurological disorders, degenerative changes in the bowel's blood supply, or after-effects of some radiation therapies. There are currently estimated to be 44,000 people in Australia living with a stoma.
- Stomal therapy nurses have undertaken specialist education to achieve an advanced level of theoretical knowledge and clinical skills through programs offered at educational or hospital-based facilities. Stomal therapy nurses hold a Graduate Certificate or a Certificate recognized by the Australian Association of Stomal Therapy Nurses. Stomal therapy nurses, as well as the treating surgeons, assist patients to access stomal therapy products available under the Australian Government Stoma Appliance Scheme. At the present time, there is no provision within the MBS for stomal therapy services.
- Currently, there is wide disparity in access to services provided by stomal therapy nurses across Australia. It is often more difficult for private hospital patients and for patients in regional and remote areas to access stomal therapy services, particularly following discharge from hospital. Access to services is further impaired by a shortage of nurses with sufficient stomal therapy qualifications. This may

compromise appropriate care for patients who have had ostomy surgery and impact on the patient's physical, social and emotional outcomes.

4.2. Enhanced Recovery after Surgery (ERAS)

Recommendations

- Amend the Explanatory Notes of MBS items 32000, 32003, 32004, 32005, 32009, 32012, 32015, 32018, 32021, 32024, 32025, 32026 and 32028 to include advice that for these procedures, the patient should be managed utitilising ERAS principles where appropriate.
- Recommend that the MBS Review Taskforce consider providing advice to the Department of Health suggesting the need for ERAS protocols to be incorporated into the Explanatory Notes of all suitable surgical procedures including colorectal, orthopaedic, urological and pancreatic surgeries.

Rationale

Enhanced recovery after surgery (ERAS) (fast-track) programs are comprehensive multimodal perioperative pathways, which aim to reduce surgical stress, maintain postoperative physiological function, and enhance mobilisation after surgery (8) (9).

These recommendations seek to optimise recovery for surgical patients through decreased length of hospital stay, faster restoration of gut function, reduced morbidity and an early return to normal activities among colorectal surgery patients (8) (9).

ERAS protocols are applied via multidisciplinary pathways, encompassing peri- and postoperative elements, including:

- Education and counselling;
- Perioperative focus on improved well-being through:
    - Exercise;
    - Nutrition;
    - Cessation of smoking; and
    - Perioperative nutritional supplements.
- Avoidance of bowel preparation, nasogastric tubes and drains.
- Appropriate medication, including:

- Multimodal antiemetics;
- Multimodal analgesia;
- Venous thromboembolism prophylaxis; and
- Prophylactic antibiotics.

- Early postoperative mobilisation.
- Early postoperative nutrition.
- Early return to normal activities.

4.3. Consumer Health Literacy

Recommendations

- The Committee supported the recommendations of the Specialist and Consultant Physicians Consultations Clinical Committee of the MBS Review; *Recommendation 10: Improve patient consent and shared decision-making*.
- The Committee endorses best clinical practice in line with the Royal College of Surgeons' Position Paper: *Informed Consent* and emphasises the need for patient access to appropriate and readily understandable information about treatment options, associated risks and the expected outcomes (10).
- The Committee encourages increased patient education of available resources such as those available through the Colorectal Surgical Society of Australia and New Zealand (11).

Rationale

The Committee emphasises the importance of consumers being well supported when considering undergoing colorectal surgery procedures. This support is given through patient education that enables the consumer to give informed consent prior to a procedure being performed. Over 50% of Australian adults do not have a level of health literacy needed to understand health information (12). This can influence health care decisions, with low levels of health literacy associated with undesirable health outcomes such as low participation in preventative programs and poor medication adherence (13).

The Committee considers that consultation with a colorectal surgeon should include the provision of appropriate written and visual material that accurately describes the procedure,

alternative options where possible, and information regarding the patient's medical condition. Provision of educational materials helps to improve consumer understanding and allows for accurate information to be conveyed to carers and family members.

Item level recommendations

4.4. Hemicolectomy, total colectomy and rectal resection items

A hemicolectomy involves the surgical removal of a section of the colon; either the right or left portion. Some patients may also require the formation of a stoma. A hemicolectomy may be performed as a surgical treatment for bowel cancer, polyps, diverticulitis or inflammatory bowel disease (IBD).

A total colectomy involves removing the entire abdominal colon. A proctocolectomy involves removing both the abdominal colon and rectum, with or without the removal of the anal canal and sphincter complex.

Rectal resection involves the removal of part of the large intestine which is located within the pelvis, surrounded by other important organs, large blood vessels and the nerves required for sexual, bladder and bowel function. Safe and complete removal of tumours involving the rectum is therefore considered more difficult than other parts of the large bowel, with a much higher chance of tumour recurrence compared with operations on large bowel located within the abdomen. Similarly, any restorative procedures after rectal resection are more likely to have complications such as anastomotic leak or damage to adjacent structures. A temporary defunctioning stoma is often required to allow the anastomoses to heal.

A minimally-invasive surgical (MIS) approach to removal of the colon and rectum has become standard and preferred technique, when clinically appropriate. This has typically involved the use of laparoscopy with better patient-related outcomes when compared with traditional open surgery. Many studies have demonstrated that laparoscopy is more cost-effective and produces better patient outcomes than open colorectal surgery. Minimally invasive colorectal surgery is now the considered standard that should be offered to patients providing value to both patient and provider (14). However, the degree of training and the length of operation to safely complete these operations by a MIS approach are significantly greater, especially for patients with increased body mass index. Appropriately, clinicians would typically co-claim the laparoscopy item number 30390 in addition to the relevant item for colectomy.

The Committee reviewed 14 hemicolectomy, total colectomy and rectal resection items.

Following the review of these items, the Committee recommended that:

- Five hemicolectomy, total colectomy and rectal resection items remain unchanged.
- The descriptors of nine items are amended.

Tables 3 to 6, below, show the standard Medicare service and benefits data considered during this review of hemicolectomy, total colectomy and rectal resection items. All data is by date of processing for the 2016/17 FY.

4.4.1. Recommendation 1

Table 3: Standard Medicare data for hemicolectomy, total colectomy and rectal resection items 32000 to 32015, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32000	Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)	$1,031.35	779	$532,209.60	11.40%
32003	Large intestine, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	$1,078.80	4,157	$3,245,554.90	1.18%
32009	Total colectomy and ileostomy (Anaes.) (Assist.)	$1,364.60	121	$120,068.21	-2.87%
32012	Total colectomy and ileorectal anastomosis (Anaes.) (Assist.)	$1,507.40	147	$163,225.35	-3.32%
32015	Total colectomy with excision of rectum and ileostomy 1 surgeon (Anaes.) (Assist.)	$1,852.50	74	$101,277.55	-0.53%

Recommendation: Leave five hemicolectomy, total colectomy and rectal resection items unchanged.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.4.2. Recommendation 2

Table 4: Standard Medicare data for hemicolectomy item 32006, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)	$1,150.35	853	$508,628.95	1.42%

Recommendation: Amend the descriptor for item 32006 to restrict co-claiming with items 32024, 32025, 32026 and 32028.

The Committee recommended item 32006 be amended to include a restriction on co-claiming these items at the same time as item 32030.

- It is recommended the amended descriptor for item 32006 read:
    - *"*Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.). Only to be co-claimed with items 32024, 32025, 32026 and 32028*"*

Rationale

Item 32006 refers to the surgical procedure to remove the left side of the large bowel, known as a left hemicolectomy. If this is procedure is performed in conjunction with the creation of a stoma (an opening of the bowel onto the abdomen to allow the passage of stool), then item 32030 can be claimed. If a left hemicolectomy is performed in conjunction with the formation of an anastomosis, then item 32003 can be claimed. As a left hemicolectomy is always performed with either creation of a stoma or formation of an anastomosis, there is no other clinical reason to claim item 32006, rather than either 32030 or 32003.

The Committee noted data indicating some practitioners have been combined claiming (co-claiming) item 32006 with either item 32024 (high restorative anterior resection of the rectum with intraperitoneal anastomosis greater than 10cm from the anal verge), item 32025 (low restorative anterior resection of the rectum with extraperitoneal anastomosis less than 10cm from the anal verge) or item 32026 (ultra low restorative resection of the rectum, with or without covering stoma, with anastomosis 6cm or less from the anal verge). This co-claiming practice was previously appropriate when the splenic flexure of the colon had been mobilised in order to provide better mobilisation and potentially less tension on the anastomosis. However, as this practice of splenic flexure mobilisation is now considered a standard part of left colon/rectal resections, the Committee agreed it is no longer appropriate to co-claim these items together. The Committee considered whether item 32006 should be deleted from the MBS. However, it agreed there may be role for the item for the purpose of the collection of data regarding left hemicolectomy services. Therefore, it agreed to recommend item 32006 be retained on the MBS but co-claiming restricted with items 32024, 32025, 32026 and 32028. This change serves to ensure the service is only co-claimed with other items if it is clinically appropriate and justifiable to do so.

4.4.3. Recommendation 3

Table 5: Standard Medicare data for subtotal colectomy items 32004 and 32005, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32004	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.)	$1,150.35	69	$55,263.05	1.84%
32005	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.)	$1,299.55	404	$386,628.20	-0.10%

Recommendation: Amend the item descriptors for subtotal colectomy items 32004 and 32005.

The Committee recommended items 32004 and 32005 be amended to include a restriction on co-claiming these items at the same time as item 32030.

- It is recommended the amended descriptor for item 32004 read:
    - *"Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005, 32006 or 32030 applies (Anaes.) (Assist.)."*
- It is recommended the amended descriptor for item 32005 read:
    - *"Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004, 32006 or 32030 applies (Anaes.) (Assist.)."*

Rationale

The Committee recommended that items 32004 and 32005 should include a restriction on co-claiming of either item at the same time as item 32030. This is because the procedure to perform a left hemicolectomy with formation of a stoma should not be claimed at the same time as the procedures described by items 32004 and 32005.

The Committee discussed the potential need for a new item number for extended right hemicolectomies (extending beyond the right branch of the middle colic). This procedure is considered more challenging than a standard right hemicolectomy and the Committee agreed that the need for this item should be considered by a future review of colorectal surgery item numbers.

4.4.4. Recommendation 4

Table 6: Standard Medicare data for rectal resection items 32024 to 32033, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)	$1,364.60	1,754	$1,767,063.25	-0.20%
32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)	$1,825.30	1,233	$1,668,291.35	2.82%
32026	Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.)	$1,965.65	819	$1,188,534.55	-2.11%
32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.)	$2,106.20	92	$143,277.50	11.24%
32030	Rectosigmoidectomy (Hartmann's operation) (Anaes.) (Assist.)	$1,031.35	517	$376,600.10	2.36%
32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.)	$1,507.40	368	$402,452.85	3.29%

Recommendation: Amend the item descriptors for items 32024, 32025, 32026, 32028, 32030 and 32033.

The Committee recommended the descriptors for items 32024 and 32025 be amended to include restrictions on co-claiming with items 32000 or 32030.

The Committee recommended the item descriptor for item 32026 be amended to include a restriction on co-claiming this item at the same time as items 32000, 32030, 32103, 32104, 32106 and 32117.

Additionally, the Committee recommended that:

- The Explanatory Notes for items 32025, 32026 and 32028 be amended to include the following:

  "These procedures should be performed with the following requirements:

  - *In an appropriate setting with HDU/ICU availability,*
  - *Include multidisciplinary team discussion of patient,*
  - *Have patient managed using Enhanced Recovery after Surgery (ERAS) principles,*
  - *In a setting with adequate access to stomal therapy nurse services."*

- The item descriptor for item 32024 be amended to read:

  - *"Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32000, 32030, 32103, 32104 or 32106 applies (Anaes.) (Assist.)."*

- The item descriptor for item 32025 be amended to read:

  - *"Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma not being a service associated with a service to which item 32000, 32030, 32103, 32104 or 32106 applies (Anaes.) (Assist.)."*

- The item descriptor for item 32026 is recommended to be:

  - *"Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge not being a service*

associated with a service to which item 32000, 32030, 32103, 32104, 32106 or 32117 applies (Anaes.) (Assist.).”

- The item descriptor for item 32028 be amended to read:
    - *“Rectum, low or ultra-low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir not being a service associated with a service to which item 32000, 32030, 32103, 32104, 32106 or 32117 applies (Anaes.) (Assist.).”*
- The Explanatory Note of item 32028 be amended to include additional wording as follows:
    - *“This item is appropriately used by 1 surgeon incorporating transanal total mesorectal excision.”*
- The Committee recommended the item descriptor for item 32030 be amended to read:
    - *“Rectosigmoidectomy, including formation of stoma (Anaes.) (Assist.).”*
- The Committee recommended the item descriptor for item 32033 be amended to read:
    - *“Restoration of bowel continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (Anaes.) (Assist.).”*

Rationale

The construction of a colonic reservoir can assist in improved postoperative rectum function by decreasing rates of stool urgency and incontinence. Currently, the creation of a colonic reservoir is listed on the MBS as item 32029. This is often performed and co-claimed with either 32026 or 32028. One of the aims of this review has been to develop complete medical services and so one of the recommendations of this report is the deletion of item 32029; therefore it becomes appropriate for rectum resection items 32026 and 32028 to incorporate construction of a colonic reservoir within their descriptors. Inclusion of the wording ‘with or without colonic reservoir’ allows for clinical judgement as to whether construction of a colonic reservoir is deemed appropriate in the procedure. The fee for items 32026 and 32028 should be increased to reflect the incorporation of constructing a colonic reservoir as part of these procedures.

It is inappropriate for item 32026 to be claimed at the same time as items 32000, 32006 or 32030 while this practice was historically appropriate when the splenic flexure of the colon had been mobilised to provide better mobilisation of the anastomosis, with potentially less tension placed upon it. However, this practice of splenic flexure mobilisation is currently considered a standard part of rectal resections meaning that it is no longer appropriate to co-claim these items.

It is inappropriate for item 32025, 32026 or 32028 to be claimed at the same time as the procedure for abdominal rectopexy, item 32117. Co-claiming these items implies that there was insufficient length of rectum remaining to warrant the rectopexy. In the situation where a resection is required when performing a rectopexy, the anastomosis should ideally be above 10cm from the anal verge as this provides the patient with adequate function.

The Committee recommended that the word “Hartmann’s” be removed from the item descriptor for items 32030 and 32033 as it is considered unnecessarily specific and rarely performed in the same manner as the original description by Hartmann (i.e. not usually with mucous fistula). However, the Committee noted it is also appropriate to claim item 32030 for patients who have a large amount of rectum dissected, a procedure not accurately described as a Hartmann’s procedure.

The Committee noted the patient benefit derived from the adoption of ERAS modifications into these surgeries, in addition to those associated with the procedure being performed in a setting with available stomal nursing support. The Committee agreed the inclusion of explanatory notes emphasising the importance of these aspects of patient care would encourage their use. It was agreed that an explanatory note regarding access to stomal therapy services should be included for all procedures where a stoma is formed or reversed (including item 32033).

4.5. Synchronous surgeries

After considering the appropriateness of items relating to colectomy in contemporary surgical practice, the Committee recommended that:

- No change to nine items for synchronous surgery.
- Seven new synchronous surgery items be created.

4.5.1. Recommendation 5

Table 7: Standard Medicare data for items for total colectomy by synchronous surgery, 32018 and 32021, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; abdominal resection (including aftercare) (Anaes.) (Assist.)	$1,570.85	11	$12,959.65	1.92%
32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; perineal resection (Assist.)	$563.30	31	$12,611.05	44.04%

Recommendation: No change to items 32018 and 32021.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.5.2. Recommendation 6

Table 8: Standard Medicare data for abdominoperineal resection by synchronous surgery items 32042 and 32045, 2016/17. Current combined fee of pair: $1,777.10.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)	$1,293.15	38	$35,377.50	-5.71%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.)	$483.95	30	$10,376.30	3.71%

Recommendation: No change to items 32042 and 32045.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.5.3. Recommendation 7

Table 9: Standard Medicare data for synchronous surgery item 32046, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.)	$747.90	13	$6,458.00	-9.15%

Recommendation: No change to item 32046.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.5.4. Recommendation 8

Table 10: Standard Medicare data for total colectomy by synchronous surgery items 32054 and 32057, 2016/17. Current combined fee of pair: $2,689.50.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32054	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$2,126.20	2	$2,126.20	-24.21%
32057	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)	$563.30	1	$563.30	-34.02%

Recommendation: No change to items 32054 and 32057.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.5.5. Recommendation 9

Table 11: Standard Medicare data for synchronous surgery items 32063 and 32066, 2016/17. Current combined fee of pair: $2,689.50.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$2,126.20	3	$2,126.20	

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.)	$563.30	6	$563.30	24.57%

Recommendation: No change to items 32063 and 32066.

Rationale

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.

4.5.6. Recommendation 10

Table 12: Create four new item numbers for the abdominal component of taTME procedures.

Item	Descriptor
320AR	Trans-abdominal component of an ultra-low anterior resection where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision) ($1364.60)
320TC	Trans-abdominal component of a restorative proctocolectomy where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision). ($1507.40)
320HP	Trans-abdominal component of an abdomino-perineal resection of rectum and anus where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision). ($1031.35)
320PC	Trans-abdominal component of a pan-proctocolectomy where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis via the perineal incision. ($1150.35)

Table 13: Create three new item numbers for the perineal component of taTME procedures.

Item	Descriptor
320ST	Perineal component of an ultra-low anterior resection or restorative proctocolectomy with stapled anastomosis where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision). ($1202.05)
320HS	Perineal component of an ultra-low anterior resection or restorative proctocolectomy with partial inter-sphincteric dissection and hand sewn colo-anal anastomosis where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision). ($1483.20)
320EA	Perineal component of an abomino-perineal resection or rectum and anus or pan-proctocolectomy where the rectal dissection is performed by a technique involving the use of a digital viewing platform and pneumopelvis (trans-anal total mesorectal excision). ($1031.35)

Recommendation: Create four new items for the abdominal component of taTME procedure items and three new items for the perineal component of taTME.

The Committee recommended the Explanatory Notes for the proposed new items 320AR, 320TC, 320HP, 320PC, 320ST, 320HS and 320EA include the following:

- *"That this procedure be performed with the following requirements:*
  - *Be performed in an appropriate setting with ICU availability,*
  - *Multidisciplinary team discussion of patient with rectal cancer,*
  - *Have patient managed using Enhanced Recovery after Surgery (ERAS) principles.*

- A single surgeon performing a taTME procedure should claim one abdominal number and one perineal number. The lower of the two fees will, as per the 100:50:25 rule, be 50% of the quoted fee. Two surgeons performing synchronous taTME surgery will each claim one item number and would each claim 100% of the fee.
- 320HP and 320PC are always claimed with 320EA.
- 320AR and 320TC can be claimed with either 320ST or 320HS.
- In cases where one surgeon is responsible for all the aftercare of the patient the surgeons can negotiate between themselves whether the remuneration split

between them is fair and come to a financial arrangement amongst themselves such that one surgeon agrees to pay the other surgeons a portion of their fee to compensate their colleague doing the aftercare.

- Additionally, the Committee recommended the proposed schedule fee for item 320AR be $1,364.60.
- Additionally, the Committee recommended the proposed schedule fee for item 320TC be $1,507.40.
- Additionally, the Committee recommended the proposed schedule fee for item 320HP be $1,031.35.
- Additionally, the Committee recommended the proposed schedule fee for item 320PC be $1,150.35.
- Additionally, the Committee recommended the proposed schedule fee for item 320ST be $1,202.05.
- Additionally, the Committee recommended the proposed schedule fee for item 320HS be $1,483.20.
- Additionally, the Committee recommended the proposed schedule fee for item 320EA be $1,031.35.

Rationale

Over the past 40 years there have been a number of advances in the surgical removal of the rectum and surrounding tissues (mesorectum), primarily for the treatment of rectal cancer. This is referred to as total mesorectal excision (TME) and is considered the standard surgical treatment for rectal cancer. This had previously been performed by “open” surgery via a long abdominal incision. More recently, TME surgery has included the use of minimally-invasive surgical (MIS) approaches such as laparoscopy and robotics, with similar patient oncology outcomes but without the need for a major abdominal incision. These procedures require a much greater skill set when performed using an MIS approach. There has also been the progressive uptake by colorectal surgeons to perform the difficult pelvic dissection using a transanal approach from below. This has previously been described in the 1980’s but the modern approach involves use of MIS technologies to provide enhanced visualisation using a digital viewing platform (often in 3D) and insufflation of the lower rectum and pelvis or “pneumopelvis”. This approach has become known as transanal TME (taTME). There are

many potential advantages to taTME, particularly in male patients with a narrow pelvis, low tumours close to the pelvic floor/sphincters, after pre-treatment with radiotherapy or in obese patients (15) (16).

TaTME can be performed by two surgical teams working synchronously.

The abdominal portion of the operation involves full mobilisation of the colon, high ligation of the large arteries and veins to the colon and rectum. This is typically performed using an MIS approach by the abdominal team using CO_2 pneumoperitoneum. The perineal surgical approach is performed using a digital viewing platform and pneumopelvis.

The Committee considers that taTME procedures are not currently described in the MBS. The Committee also believes that the taTME is a technique that is going to remain in use with many Australian colorectal surgeons for the foreseeable future. The Committee therefore believes that taTME should be described by new item numbers. In order to cover all the foreseeable situations where the taTME technique is used the Committee proposes the creation of 7 new item numbers. Four item numbers are to describe the various abdominal procedures that may be required, in summary resection of left colon with and without anastomosis and total colectomy with and without stoma. Three item numbers are to describe the perineal part of the procedure, in summary one involving stapled anastomosis, one hand-sewn anastomosis and one involving excision of anus. Thus for any given taTME procedure there will be two numbers claimed.

The fees proposed for taTME have as far as possible be derived to follow the principle that a procedure performed, such as resection of the rectum with TME, should receive the same remuneration regardless of what technique is chosen. The Committee derived these fees based on the opinion that the abdominal component of a taTME ultra-low anterior resection is very similar to laparoscopic high anterior resection and thus made the fee for 320AR identical to a high anterior resection (32024). The perineal fee was then derived by taking the difference in fee between 32024 and 32026 and multiplying that by two. Thus, for example the fee for a taTME involving an ultra-low anterior resection and stapled anastomosis when performed by a single surgeon (320AR + 50% 320ST) is exactly the same as the fee for a standard ultra-low anterior resection (32026). An identical method was used to calculate the fees associated with the other taTME item numbers.

Synchronous surgery with taTME potentially has advantages in dramatically shortening operating times. Synchronous surgery numbers currently in the MBS are heavily weighted towards the abdominal surgeon. With the taTME numbers proposed the fee for perineal

surgeon is very similar to that of the abdominal surgeon. A portion of any fee includes the fee for aftercare. Traditionally the abdominal surgeon is the surgeon who provides the aftercare in synchronous surgery operations, however this is often reversed with taTME surgery. The Committee considered reflecting this by developing separate numbers for the various situations when either the abdominal or perineal surgeon was delivering aftercare; however, after receiving stakeholder feedback the Committee abandoned this as the various combinations created overly complex item numbers. As this is always the case, the two surgeons can choose to split the fees between themselves anyway they see fit by one paying the other an agreed portion of their fee to compensate for aftercare.

The combined fees associated with synchronous surgery are also very similar to the current fees with synchronous surgeries described in the MBS.

The Committee also discussed the potential advantages of a national registry where surgeons can submit their data for surgical outcomes of taTME and other procedures for the resection of colorectal cancers. Such a registry would inform future decision-making regarding the comparative outcomes associated with taTME and other methods of tumour excision. Gathering information about this technique will also be facilitated by creation of its own item numbers.

4.6. Abdominoperineal resections items – single surgeon

An abdominoperineal resection is a surgical procedure during which the sigmoid colon, rectum and anal sphincter are removed via both abdominal and perineal incisions during the surgical excision of a rectal cancer.

Surgical advances have led to the development of alternative procedures in which the anal sphincter may sometimes be spared, such as taTME. However an abdominoperineal resection is often still be necessary for rectal tumours located in the distal third of the rectum.

The Committee reviewed one abdominoperineal resection item.

4.6.1. Recommendation 11

Table 14: Standard Medicare data for abdominoperineal resection item 32039, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.)	$1,535.05	323	$343,977.00	1.56%

Recommendation: Leave abdominoperineal resection item 32039 unchanged.

Rationale

After considering standard Medicare data and clinical evidence, the Committee agreed item 32039 should remain unchanged. This is because:

- The item adequately describes the procedure.
- The procedure is required for patients in which other surgical methods of rectal tumour excision are not possible.
- The procedure is not provided under other items.
- There is unlikely misuse of this item.

4.7. Proctocolectomy and ileal pouch items

A proctocolectomy involves removal of both the abdominal colon and the rectum, with or without removal of the anal canal and sphincter complex.

The Committee reviewed three proctocolectomy and ileal pouch items.

The Committee recommended that:

- Two proctocolectomy and ileal pouch items remain unchanged; and
- The descriptor for one proctocolectomy and ileal pouch item is amended.

4.7.1. Recommendation 12

Table 15: Standard Medicare data for proctocolectomy and ileal pouch items 32051 and 32069, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32051	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)	$2,316.60	52	$88,757	-3.77%
32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)	$1,713.65	6	$7,711	-12.94%

Recommendation: Leave proctocolectomy and ileal pouch items 32051 and 32069 unchanged.

Rationale

After considering the standard Medicare data and relevant clinical evidence, the Committee agreed that items 32051 and 32069 should remain unchanged. This is because:

- The items adequately describe the procedures.
- The procedures reflect current best practice.
- The procedures are not provided under other items.
- There is unlikely misuse of these items.

4.7.2. Recommendation 13

Table 16: Standard Medicare data for proctocolectomy and ileal pouch item 32060, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.)	$2,316.60	63	$107,516	2.75%

Recommendation: Change the descriptor for item 32060.

- The Committee recommended the item descriptor for item 32060 be amended to read:
    - *"Restorative proctectomy involving rectal resection with formation of ileal reservoir and ileoanal anastomosis including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (Anaes.) (Assist.)."*

Rationale

The Committee considered an appropriate item descriptor for this item and agreed the amended descriptor better describes the procedure and reduces confusion with a standard ileostomy closure.

Since the initial description of this operation, the techniques and instruments have improved whereby a mucosectomy is often not required and now seldom performed.

4.8. Rectal tumour items

The Committee reviewed eight items for excision of rectal tumours. These items refer to local excision of the rectal tumour without removal of the adjacent mesorectum, lymph nodes or colon.

The Committee recommended that:

- Two rectal tumour items remain unchanged.
- Four rectal tumour items be combined into two items.
- The descriptors of two rectal tumour items be amended.

4.8.1. Recommendation 14

Table 17: Standard Medicare data for excision of rectal tumour item 32108, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32108	Rectal tumour, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.)	$999.65	14	$9,746.80	22.87%

Recommendation: Leave excision of rectal tumour item 32108 unchanged.

Rationale

After considering the standard Medicare data and relevant clinical evidence, the Committee agreed item 32108 should remain unchanged. This is because:

- The item adequately describes the procedure.
- The procedure reflects current best practice.
- The procedure is not provided under other items.
- There is unlikely misuse of this item.

4.8.2. Recommendation 15

Table 18: Standard Medicare data for excision of rectal tumour item 32105, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32105	Anorectal carcinoma per anal full thickness excision of (Anaes.) (Assist.)	$483.95	82	$28,261.60	-6.38%

Recommendation: Leave excision of anorectal carcinoma item 32105 unchanged.

Rationale

The Committee agreed the service provided under item 32105 is sufficiently described within items 32103 and 32099 and considered whether the item should be deleted from the MBS. Additionally, excision of small anal squamous carcinomas is appropriately claimed under item 31356.

However, the Committee noted there may be rare instances in which this item is appropriate and therefore, it should be retained.

4.8.3. Recommendation 16

Table 19: Standard Medicare data for excision of rectal tumour items 32099 and 32102, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32099	Rectal tumour of 5cm or less in diameter, per anal submucosal excision of (Anaes.) (Assist.)	$333.20	345	$72,021.95	1.26%
32102	Rectal tumour of greater than 5cm in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.)	$634.70	80	$37,190.85	-6.67%

Recommendation: Combine rectal tumour items 32099 and 32102 into one item.

- The Committee recommended that items 32099 and 32102 be combined into one item.
- The Committee recommended the fee for the new combined item be set at a level approximately equivalent to that of the lower fee item ($333.20).
- Additionally, the Committee recommended the item descriptor for the new combined item include the following:
    - *"Rectal tumour, per anal excision of (Anaes.) (Assist.)"*

Rationale

Numerous studies have demonstrated superior patient outcomes associated with the use of a digital viewing platform and pneumorectum for the removal of large rectal lesions, compared with transanal technique (15) (17) (18). However, it may be still appropriate to

remove smaller lesions by a transanal technique. The Committee agreed removing the size description on the relevant item should provide a disincentive for surgeons to attempt the removal of larger lesions without the use of digital viewing platform and pneumorectum. The Committee agreed that doing so would be inappropriate and not in line with current clinical best practice.

4.8.4. Recommendation 17

Table 20: Standard Medicare data for rectal biopsy item 32096, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)	$256.95	210	$35,579.20	10.76%

Recommendation: Amend the item descriptor for rectal biopsy item 32096.

- The Committee recommends the item descriptor for item 32096 be amended to read:
    - *"Rectal biopsy, full thickness, to diagnose or exclude Hirschsprung's Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)"*

Rationale

The Committee agreed the addition of a specific reference in the item descriptor to Hirschsprung's Disease, provides patients with the appropriate information regarding the purpose of the procedure and better describes why the procedure is done.

4.8.5. Recommendation 18

Table 21: Standard Medicare data for excision of rectal tumour items 32103, 32104 and 32106 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32103	Rectal tumour, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.)	$772.30	109	$61,875.05	0.18%
32104	Rectal tumour, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.)	$999.65	160	$117,261.10	12.96%
32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.)	$1,364.60	36	$34,275.90	12.47%

Recommendation: Combine items 32103 and 32104 into one item and amend the descriptor of item 32106.

- The Committee recommended items 32103 and 32104 be combined into one item with the item descriptor for the new combined item to read:

- *"Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.)."*

- The Committee recommended the item descriptor for item 32106 be amended to read:
  - *"Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.)."*

Rationale

There are a number of surgical platforms now available to achieve transanal excision of rectal tumours. All of these incorporate a digital viewing system and creation of space by insufflation with carbon dioxide (pneumorectum). This often involves suturing of the defect or full thickness excision of the lesion, neither of which is typically done when a polyp is removed using colonoscopy. The amended descriptors of the 32103 and 32104 combined item and the amended descriptor of item 32106 provides an updated description of the technology involved. Additionally the new descriptor provides a point of differentiation to the removal of rectal polyps during colonoscopy.

In the new item generated from combining items 32103 and 32104, the Committee recommended the size indicator be removed from the descriptor noting that while the size of the tumour may influence the time and difficulty associated with performing the operation successfully, there are a number of other factors which are more relevant. These include the height of the tumour from the anal verge, involvement of a rectal fold and previous surgery/endoscopic removal of the lesion. Removing the size description reduces the number of item numbers for this section but acknowledges the skillset required for this type of surgery.

4.9. Rectal prolapse items

Rectal prolapse is the protrusion of part of the bowel out through the anus. The level of prolapse is ranked by severity:

1. Internal (incomplete) prolapse – the rectum has prolapsed but does not protrude through the anus.
2. Mucosal – the interior lining of the rectum protrudes through the anus.
3. External (complete) – the full thickness of the rectum protrudes through the anus.

Rectal prolapse may occur in young children or in the elderly, with the exact cause unknown. Prolapse in children generally resolves without requiring surgery. In adults, mucosal prolapse is treated by rubber banding or by surgery. For external prolapse, surgery is usually required, with several different procedures that can be performed.

The Committee reviewed 10 items for the repair of rectal prolapse.

The Committee recommended that:

- Two rectal prolapse items remain unchanged.
- Two rectal prolapse items be deleted.
- Two rectal prolapse items be combined.
- Two rectal stricture items be combined.
- The descriptors for two rectal prolapse items be amended.
- One new rectal prolapse item is created.

4.9.1. Recommendation 19

Table 22: Standard Medicare data for anoplasty and rectocele repair items 32123 and 32131, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32123	Anal stricture, anoplasty for (Anaes.) (Assist.)	$333.20	166	$32,387.40	25.65%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32131	Rectocele, transanal repair of rectocele (Anaes.) (Assist.)	$533.60	214	$53,843.50	9.17%

Recommendation: Leave items 32123 and 32131 unchanged.

Rationale

After considering the standard Medicare data and clinical evidence, the Committee agreed items 32123 and 32131 should remain unchanged. This is because:

- The current items adequately describe the relevant procedures.
- The procedures reflect current best practice.
- The procedures are not provided under other items.
- There is unlikely to be misuse of these items.

4.9.2. Recommendation 20

Table 23: Standard Medicare data for repair of rectal prolapse items 32120 and 32126, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32120	Rectal prolapse, perineal repair of (Anaes.) (Assist.)	$256.95	783	$69,510.10	15.02%
32126	Anal incontinence, Parks' intersphincteric procedure for (Anaes.) (Assist.)	$483.95	11	$3,448.50	-6.01%

Recommendation: Delete items 32120 and 32126.

Rationale

After considering the standard Medicare data for items 32120 and 32126, the Committee agreed these items should be deleted from the MBS. Key considerations leading to this decision included:

- Item 32120 is frequently co-claimed with item 32139. However, there is probably insufficient justification for this to continue as a separate item, particularly considering item 32111 (Delorme procedure) more fully describes the extent of dissection required to treat rectal prolapse via a perineal approach.
- Parks' intersphinctereric procedure for anal incontinence is a rarely performed procedure with no evidence to support its continued use, especially when many newer procedures and technologies have become available for the treatment of faecal incontinence.
- In the small number of instances where this procedure is performed, it would be appropriate to claim item 32129 (repair of anal sphincter), or to consider pelvic floor neuromodulation.

4.9.3. Recommendation 21

Table 24: Standard Medicare data for repair of rectal prolapse items 32111 and 32112, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32111	Rectal prolapse, Delorme procedure for (Anaes.) (Assist.)	$634.70	950	$449,680.46	14.11%
32112	Rectal prolapse, perineal recto-sigmoidectomy for (Anaes.) (Assist.)	$772.30	37	$21,773.30	0.00%

Recommendation: Combine items 32111 and 32112 into one item

- The Committee recommended items 32111 and 32112 be combined with the item descriptor for the new item to read:
    - *"Perineal repair of rectal prolapse. Not being a service described by 32139 and not to be co-claimed with 32139. (Anaes.) (Assist.)"*

Rationale

There are currently a number of procedures available to treat rectal prolapse, which have similar degrees of complexity. As the number of services for item 32112 is expected to decrease further in the future, it would be appropriate to combine the two items.

The descriptor of the combined item is similar to the descriptor of item 32120 (now recommended for deletion). However, it is important to specify that perineal repair of prolapse should not be performed at the same time as haemorrhoidectomy items 32138 and 32139.

The Committee recommends that the fee for the new combined item is set at the previous fee of item 32111 ($634.70), based upon greater service volume.

4.9.4. Recommendation 22

Table 25: Standard Medicare data for treatment of rectal stricture items 32114 and 32115, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32114	Rectal stricture, per anal release of (Anaes.)	$174.45	134	$11,748.60	0.92%
32115	Rectal stricture, dilatation of (Anaes.)	$126.85	205	$13,767.55	2.98%

Recommendation: Combine items 32114 and 32115 into one item

- The Committee recommended items 32114 and 32115 be combined into one item with the amended descriptor for the new item to read:
    - *"Rectal stricture, treatment of (Anaes.)."*
- Additionally, the Committee recommended the fee for the combined item be approximately $126.85.

Rationale

There are currently a number of procedures available to treat rectal strictures. The services provided under items 32114 and 32115 each have a similar degree of complexity. Therefore, the Committee agreed it would be appropriate to combine the two. This would serve to simplify the MBS.

- The Committee agreed the fee for the combined item should be set at a value proportional to service volumes of items 32114 and 32115.

4.9.5. Recommendation 23

Table 26: Standard Medicare data for repair of rectal prolapse item 32117, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32117	Rectal prolapse, abdominal rectopexy of (Anaes.) (Assist.)	$999.65	671	$369,092.75	10.14%

Recommendation: Change the descriptor for item 32117.

The Committee recommended item 32117 be amended to include restrictions on co-claiming on the same day as items 32025 or 32026. The Committee also recommended that the descriptor for the item be revised to prevent the item being used for ventral rectopexy.

- The Committee recommended the amended item descriptor for item 32117 read:
    - *"Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which items 32025, 32026 applies (Anaes.) (Assist.)."*

Rationale

Treatment of rectal prolapse by an abdominal approach may include removal of the sigmoid colon for which item 32024 would be claimed. However, it would be inappropriate to remove a significant portion of the rectum during treatment of rectal prolapse by abdominal approach. Items 32025 and 32026 describe rectal resection procedures which would not be appropriately performed at the same time as item 32117 and it is recommended that a restriction on co-claiming these items should be put in place.

The Committee also considered the appropriateness of using item 32117 when performing a ventral rectopexy using a prosthesis. Although this item may, at present, be being used for ventral rectopexy, the Committee agreed that, in recommending a new item specific to ventral rectopexy (see Recommendation 25), the collection of data regarding the use of ventral versus abdominal rectopexy would be optimised if only the new ventral rectopexy item could be used when performing this procedure. Therefore, the Committee recommended the descriptor for item 32117 be revised to clarify that this item should not be used for ventral rectopexy.

Annotation: The MBS Review Taskforce recommend that the fee for item 32117 be increased to $1,256.20.

Abdominal rectopexy for the repair of rectal prolapse is considered to be a similar procedure to laparoscopic sacro-colpopexy, for which MBS item 35597 is claimed and carries a fee of $1,496.75.

Taskforce considers that item 32117, item 35597 and proposed new item 320LL (Recommendation 25 of this Report) are of similar complexity and should hold identical schedule fees. For this reason, an average of the fees (as at 13 August 2019) of item 32117 and item 35597 are recommended to apply to all three.

Taskforce notes that item 35597 is listed within Subgroup 4. Gynaecological section of the MBS and was reviewed by the Gynaecology Clinical Committee of the MBS Review.

4.9.6. Recommendation 24

Table 27: Standard Medicare data for anal sphincter repair item 32129, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32129	Anal sphincter, direct repair of (Anaes.) (Assist.)	$634.70	175	$55,574.05	-2.24%

Recommendation: Amend the item descriptor for item 32129.

- The Committee recommended the item descriptor for item 32129 be amended to read:
    - *"Anal sphincter repair (Anaes.) (Assist.)."*

Rationale

The Committee agreed the current item broadly reflects the relevant service for the direct repair of anal sphincter and that this procedure remains relevant in contemporary surgical practice. However, the Committee recommended a minor change to the wording of the item descriptor to remove superfluous words.

4.9.7. Recommendation 25

Table 28: Proposed item descriptor for recommended new item for repair of rectal prolapse.

Item	Descriptor	Schedule fee
320LL	VENTRAL RECTOPEXY Treatment of external rectal prolapse or symptomatic high grade internal rectal prolapse by laparoscopy or robotic-assistance involving and including dissection of the recto-vaginal septum to the pelvic floor, fixation of prosthesis to the rectum, with or without vaginal vault and sacrum, and including any associated pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse. Items 35595 and 35597 not to be co-claimed by the same surgeon claiming 32118. A second surgeon may claim 35597 if the patient requires synchronous repair of symptomatic upper vaginal vault prolapse involving fixation of separate prosthesis secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse.	$999.65

Recommendation: Create a new item for repair of rectal prolapse.

The Committee agreed a new item for the repair of rectal prolapse using ventral rectopexy is necessary.

- The Committee recommended the item descriptor for the new item reads:
    - *"Ventral rectopexy treatment of external rectal prolapse or symptomatic high grade internal rectal prolapse by laparoscopy or robotic-assistance involving and including dissection of the recto-vaginal septum to the pelvic floor, fixation of prosthesis to the rectum, with or without vaginal vault and sacrum, and including any associated pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse. Items 35595 and 35597 not to be co-claimed by the same surgeon claiming 32118. A second surgeon may claim 35597 if the patient requires synchronous repair of symptomatic upper vaginal vault prolapse involving fixation of separate prosthesis secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse."*
- Additionally, the Committee recommended the fee for the new item be set at a level approximately equivalent to that of the existing item for abdominal rectopexy (item 32117) which carries a Schedule fee of $999.65.

Rationale

Ventral rectopexy is a surgical procedure for treatment of external or significant internal rectal prolapse. It is currently considered the preferred treatment for surgical management of full thickness rectal prolapse (19).

Ventral rectopexy is performed via a minimally invasive approach and multiple sutures deep in the pelvis with difficult access, resulting in longer procedure duration than traditional suture or mesh rectopexy. It involves the use of a prosthesis and full mobilisation of the anterior plane of the rectum to the pelvic floor. It is a very similar procedure to the procedure 35597 laparoscopic sacro-colpopexy which is performed by gynaecologists for vaginal vault prolapse and a fee identical to that procedure may be appropriate. However, the Committee considered the fee discrepancy between the new item for ventral rectopexy and the existing item for abdominal rectopexy adopting this fee would create. Therefore, the Committee recommended the fee for the new ventral rectopexy item be set at the same level as that for item 32117 ($999.65).

The Committee discussed the importance of collecting accurate data regarding the use of ventral rectopexy (compared to abdominal rectopexy) in Australia. The Committee agreed that future decision making regarding appropriate funding for procedures would be better informed if a registry were developed to monitor the performance of rectopexy procedures being undertaken in Australia. Data obtained would include the surgical approach prosthesis used (biological or synthetic) so that patient outcomes and trends in use of the respective techniques could be compared.

Annotation: The MBS Review Taskforce recommend that the fee for new item 320LL be set at $1,256.20.

Ventral rectopexy for the repair of rectal prolapse is considered to be a similar procedure to laparoscopic sacro-colpopexy, for which MBS item 35597 is claimed and carries a fee of $1,496.75.

Taskforce considers that item 32117, item 35597 and proposed new item 320LL (Recommendation 25 of this Report) are of similar complexity and should hold identical schedule fees. For this reason, an average of the fees (as at 13 August 2019) of item 32117 and item 35597 are recommended to apply to all three.

Taskforce notes that item 35597 is listed within Subgroup 4. Gynaecological section of the MBS and was reviewed by the Gynaecology Clinical Committee of the MBS Review.

4.10. Haemorrhoid, fistula and abscess items

The Committee reviewed 19 items for the treatment of haemorrhoids, fistula and abscesses.

The Committee recommended that:

- One haemorrhoid item, three fistula items and two abscess items to remain unchanged.
- Three haemorrhoid items and one fistula item be deleted.
- Two anal skin tag/anal polyp excision items to be combined.
- Two anal wart items to be combined.
- The descriptors for two haemorrhoidectomy items, two fissure items and one fistula item be amended.

4.10.1. Recommendation 26

Table 29: Standard Medicare data for haemorrhoidectomy, fistulae and abscess items 32147, 32159, 32162, 32166, 32174 and 32175, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32147	Perianal thrombosis, incision of (Anaes.)	$45.10	2,818	$105,997.42	-4.85%
32159	Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)	$333.20	2,858	$638,644.45	2.27%
32162	Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)	$483.95	1,719	$607,221.40	6.06%
32166	Anal fistula - readjustment of Seton (Anaes.)	$206.20	528	$79,392.65	-2.23%
32174	Intra-anal, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	$88.80	384	$27,017.20	-7.98%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32175	Intra-anal, perianal or ischio-rectal abscess, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.)	$162.65	1,996	$186,507.71	2.18%

Recommendation: Leave items 32147, 32159, 32162, 32166, 32174 and 32175 unchanged.

Rationale

The Committee considered the standard Medicare data and clinical evidence related to the current services for haemorrhoidectomy, repair of anal fistula and drainage of ischiorectal abscesses and recommended the current items remain unchanged. This is because:

- These items adequately describe the relevant procedures.
- The procedures are reflective of current best practice.
- The procedures are not provided under other items.
- There is unlikely to be misuse of these items.

4.10.2. Recommendation 27

Table 30: Standard Medicare data for items for repair of haemorrhoids and fistulae, 32132, 32138, 32153 and 32168, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32132	Haemorrhoids or rectal prolapse sclerotherapy for (Anaes.)	$45.10	3,646	$71,919.80	-6.81%
32138	Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.)	$367.75	1,694	$452,798.40	-1.67%
32153	Anus, dilatation of, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.)	$70.10	104	$5,270.05	-3.30%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32168	Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (Anaes.)	$131.75	85	$7,908.90	-5.70%

Recommendation: Delete haemorrhoidectomy items 32132, 32138 and 32153 and review of fistula item 32168.

Rationale

The Committee considered the standard Medicare data and current clinical evidence for these items. In addition, it considered the relevance of these items and whether their services are currently accounted for by other items listed on the MBS. After considering these factors, the Committee agreed that:

- The Committee recommended item 32132 be deleted as item 32135 sufficiently provides for haemorrhoid or rectal prolapse treatment.
- The Committee recommended item 32138 be deleted as item 32139 sufficiently provides the haemorrhoidectomy service described by the item.
- The Committee recommended item 32153 be deleted as item 32171 sufficiently provides this procedure.
- The Committee recommended item 32168 be deleted as there are other item numbers that can be claimed for review of wounds and this item is considered non-specific.

4.10.3. Recommendation 28

Table 31: Standard Medicare data for excision of anal skin tag/anal polyps items 32142 and 32145, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32142	Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)	$67.50	737	$37,542.65	-2.79%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32145	Anal skin tags or anal polyps, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.)	$135.05	3,579	$217,464.08	4.74%

Recommendation: Combine items 32142 and 32145 into one item.

- The Committee recommended items 32142 and 32145 be combined into one item with the amended item descriptor for the new item to read:
    - *"Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)."*
- The Committee recommended the fee for the new combined item be set at an intermediate value between items 32142 and 32145 based upon service volume.

Rationale

After considering the relevance of these items in contemporary surgical management of anal skin tags or anal polyps, the Committee agreed there is no valid justification for a difference in fees to exist for these services on the basis of the setting in which the procedure is performed. Therefore, the Committee agreed these items should be combined so as to simplify and streamline the MBS.

4.10.4. Recommendation 29

Table 32: Standard Medicare data for items for anal wart removal, 32177 and 32180, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32177	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)	$174.25	293	$32,004.35	2.26%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32180	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)	$256.95	76	$12,134.40	0.00%

Recommendation: Combine items 32177 and 32180 into one item.

- The Committee recommended items 32177 and 32180 be combined into one item with the amended item descriptor for the new item to read:
    - *"Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)."*

Rationale

After considering the relevance of these services in contemporary surgical practice, the Committee agreed it is inappropriate to spend more than 45 minutes removing anal warts during one session. This is because this practice can create a large, raw area of skin which can be painful for the patient. The Committee agreed that, if anal wart removal of this magnitude were necessary, it would be more appropriate to perform the removal over more than one session to improve patient comfort. Therefore, the Committee agreed the current items be combined into one, with no specification of the time taken to perform the procedure.

4.10.5. Recommendation 30

Table 33: Standard Medicare data for items for the treatment of haemorrhoids, fissures and fistulae, 32135, 32139, 32150, 32156 and 32165, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32135	Haemorrhoids or rectal prolapse rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.)	$67.50	30,690	$829,292.64	1.85%
32139	Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.)	$367.75	6,277	$1,565,090.25	5.39%
32150	Operation for fissureinano, including excision or sphincterotomy but excluding dilatation only (Anaes.) (Assist.)	$256.95	3,330	$492,097.50	-0.13%
32156	Fistula-in-ano, subcutaneous, excision of (Anaes.)	$131.75	305	$21,395.90	-2.99%
32165	Anal fistula, repair of by mucosal flap advancement (Anaes.) (Assist.)	$634.70	402	$184,249.30	10.68%

Recommendation: Amend the item descriptors for haemorrhoidectomy items 32135 and 32139, fissure items 32150 and 32156 and fistula item 32165.

The Committee recommended the item descriptors for items 32135, 32139, 32150, 32156 and 32165 be amended to more appropriately reflect the modern surgical treatment of these conditions.

- The Committee recommended the amended item descriptor for item 32135 read:
    - *"Treatment of haemorrhoids or rectal prolapse including rubber band ligation or sclerotherapy for, where 32139 does not apply (Anaes.)."*
- The Committee recommended the amended item descriptor for item 32139 read:
    - *"Operative treatment of haemorrhoids involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed, not*

being a service to which items 32111, 32112 or 32135 applies (Anaes.) (Assist.).”

- The Committee recommended the amended item descriptor for item 32150 read:
    - *“Operation for anal fissure, including excision, injection of Botulinum toxin or sphincterotomy, excluding dilation (Anaes.) (Assist.).”*
- The Committee recommended the amended item descriptor for item 32156 read:
    - *“Anal fistula, subcutaneous, excision of (Anaes.).”*
- The Committee recommended the amended item descriptor for item 32165 read:
    - *“Operative treatment of anal fistula, repair by mucosal advancement flap, including ligation of inter-sphincteric fistula tract (LIFT) or other complex sphincter sparing surgery (Anaes.) (Assist.).”*

Rationale

The Committee recommended the items numbers for the treatment of haemorrhoids be simplified. These are intended to reflect currently performed operative and non-operative procedures and will allow for addition of new procedures.

- Item 32135 includes all non-operative haemorrhoid treatments including rubber band ligation and sclerotherapy.
- Item 32139 includes all forms of operative haemorrhoid treatments but excludes procedures for rectal prolapse which should not be co-claimed.

Additionally, the Committee recommended the wording of the descriptor for item 32150 be changed from ‘fissureinano’ to ‘anal fissure’ to reflect more contemporary nomenclature and the words ‘injection of Botulinum toxin’ be added to the descriptor. In making this recommendation, the Committee noted the injection of Botulinum toxin into the internal sphincter muscle is now an accepted method of treatment for anal fissures. The Committee noted the inclusion of the Botulinum toxin pharmaceutical in the descriptor for the item may need to be considered by MSAC. Additionally, consideration by the Pharmaceutical Benefits Advisory Committee would be necessary to obtain listing on the Pharmaceutical Benefits Schedule for this purpose.

Similarly, the Committee recommended the wording of the descriptors for items 32156 and 32165 be changed from ‘fistulainano’ to ‘anal fistula’ to reflect more contemporary nomenclature.

4.11. Graciloplasty items

Graciloplasty is a surgical procedure in which the gracilis muscle is transposed into the anus for the treatment of intractable faecal incontinence. The muscle is implanted along with an electrode from an electric pulse generator.

The Committee reviewed four graciloplasty items.

The Committee recommends that all graciloplasty items are deleted from the MBS.

4.11.1. Recommendation 31

Table 34: Standard Medicare data for graciloplasty items 32200, 32203, 32206 and 32209, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32200	Distal muscle, devascularisation of (Anaes.) (Assist.)	$295.70	2	$443.60	-
32203	Anal or perineal graciloplasty (Anaes.) (Assist.)	$635.00	1	$476.25	-
32206	Stimulator and electrodes, insertion of, following previous graciloplasty (Anaes.) (Assist.)	$573.70	2	$645.45	-
32209	Anal or perineal graciloplasty with insertion of stimulator and electrodes (Anaes.) (Assist.)	$921.95			-100.00%

Recommendation: Delete all graciloplasty items.

Rationale

The Committee noted the extremely low service volumes for these items. The Committee agreed that, since the introduction of sacral neuromodulation, graciloplasty is no longer considered as the best surgical approach for management of faecal incontinence. The procedure carries considerable risk of complications including pain, infection of the surgical site or issues with the electronic device. Therefore, the service should not be funded under the MBS and should be deleted due to concerns about patient safety.

4.12. Sacral nerve lead items

Sacral nerve stimulation (also called sacral neuromodulation) is used in the treatment of faecal incontinence. Placement of a neurostimulator delivers electrical stimulation to a sacral nerve, which can improve continence.

The Committee reviewed seven items related to the placement, replacement and removal of sacral nerve leads.

The Committee recommended that:

- Three sacral nerve items be combined; and
- The descriptors of four items be amended.

The Committee considered co-claiming data for items related to the placement, programming and removal of sacral nerve stimulators or leads and agreed some of these items could be combined into a complete medical service. There were nine instances during FY2016/17 where items 32213, 32214, 32215, 32217 and 32218 were co-claimed together in the one episode (see Table 35).

Table 35: Co-claiming of sacral nerve items, 2016/17.

Item	Descriptor	Schedule fee
32213	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.)	$660.95

Item	Descriptor	Schedule fee
32214	Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.)	$334.00
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months –each day	$125.40
32217	Neurostimulator or receiver, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.)	$156.30
32218	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or	$156.30

Item	Descriptor	Schedule fee
	i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.)	

4.12.1. Recommendation 32

Table 36: Standard Medicare data for sacral nerve items 32210, 32214 and 32217, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32210	Gracilis neosphincter pacemaker, replacement of (Anaes.)	$255.45	4	$791.95	-10.59%
32214	Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.)	$334.00	306	$54,717.45	8.55%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32217	Neurostimulator or receiver, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.)	$156.30	128	$9,385.35	23.81%

Recommendation: Combine sacral nerve items 32210, 32214 and 32217 into one item.

The Committee recommended items 32210, 32214 and 32217 be combined into one item with the item descriptor of the combined item to read:

> *"Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence (Anaes.) (Assist.)."*

Rationale

Public funding through the MBS for sacral nerve stimulation has been available since 2005. At that time, there was a lack of evidence for the effectiveness of sacral nerve stimulation in patients with sphincter defects. Since 2005 there has been an increased evidence base for this procedure.

The Committee recommended the removal of the 12 month patient waiting period from the descriptor of the combined item as patients have often undergone a period of non-operative management before getting to the point of referral to a colorectal surgical specialist for consideration for stimulation and will have already endured a lengthy period of faecal incontinence.

The previous wording within items 32214 and 32217 'anatomically intact but functionally deficient' are recommended for removal from the new combined item descriptor as evidence indicates clinical validity outside this requirement (20) (21) (22) (23) (24).

4.12.2. Recommendation 33

Table 37: Standard Medicare data for sacral nerve items 32213, 32215, 32216 and 32218, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32213	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non‑surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.)	$660.95	445	$220,537.33	2.78%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months–each day	$125.40	1,465	$141,098.55	13.58%
32216	Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.)	$593.55	28	$12,464.85	28.47%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32218	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.)	$156.30	85	$4,687.90	18.10%

Recommendation: Amend the item descriptors for sacral nerve items 32213, 32215, 32216 and 32218.

- The Committee recommended the item descriptor for item 32213 be amended to read:
    - *"Sacral nerve lead(s), placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence."*
- The Committee recommended the item descriptor for item 32215 to read:
    - *"Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence.*

      Not to be claimed more than once per day by the same practitioner for the same patient. Not being a service associated with a service to which items 32213, 32214, 32216, 32217 or 32218 applies."

- The Committee recommended the item descriptor for item 32216 be amended to read:
    - *"Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.)."*
- The Committee recommended the item descriptor for item 32218 be amended to read:
    - *"Sacral nerve lead or leads, removal (Anaes.)."*

Rationale

The previous restrictions on the use of sacral nerve stimulation (SNS) were provided by the initial clinical trial in order to minimise heterogeneity. However, published evidence supports the use of SNS in these patients with significant clinical benefit and improved quality of life.

4.13. Diagnostic item

The Committee reviewed one diagnostic procedure used in the diagnosis of abnormalities of the pelvic floor.

4.13.1. Recommendation 34

Table 38: Standard Medicare data for diagnosis of abnormalities of the pelvic floor, item 11833, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	$249.75	3,304	$692,054.75	3.5%

Recommendation: Leave diagnostic item 11833 unchanged.

Rationale

After considering the standard Medicare data and contemporary clinical evidence associated with this service, the Committee agreed the item should be left unchanged. This is because:

- This item adequately describes the procedure.
- The procedure reflects current best practice.
- The procedure is not provided under other items.
- There is unlikely to be misuse of these items.

4.14. Ungrouped colorectal surgery items

The Committee reviewed nine ungrouped colorectal surgery items.

The Committee recommended that within this group:

- Five items remain unchanged.
- Three items be deleted.
- The descriptors of one item be amended.

4.14.1. Recommendation 35

Table 39: Standard Medicare data for ungrouped colorectal surgery items 32036, 32047, 32183, 32186 and 32212, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32036	Sacrococcygeal and presacral tumour excision of (Anaes.) (Assist.)	$1,911.80	82	$98,287.35	9.54%
32047	Perineal proctectomy (Anaes.) (Assist.)	$871.30	17	$9,088.35	-5.03%
32183	Intestinal sling procedure prior to radiotherapy (Anaes.) (Assist.)	$561.65	15	$2,843.85	-7.37%
32186	Colonic lavage, total, intraoperative (Anaes.) (Assist.)	$561.65	96	$25,201.75	1.08%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32212	Ano-rectal application of formalin in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.)	$136.25	68	$4,731.45	-13.32%

Recommendation: Leave colorectal surgery items 32036, 32047, 32183, 32186 and 32212 unchanged.

Rationale

The Committee considered the relevance of the service associated with item 32036. The Committee agreed this item represents an isolated resection to remove tumours and is generally not performed with other procedures.

Item 32183 is a rarely performed procedure used for the treatment of gynaecological cancers. While infrequently used, this procedure remains relevant in contemporary surgical management of some conditions and is recommended to remain unchanged.

The Committee noted:

- The items adequately describe the procedures.
- The procedures are reflective of current best practice.
- The procedures are not provided under other items.
- There is unlikely misuse of these items.

4.14.2. Recommendation 36

Table 40: Standard Medicare data for ungrouped colorectal surgery items 32029, 32220 and 32221, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32029	Colonic reservoir, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.)	$421.20	218	$27,576.80	-9.09%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32220	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction or radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	$903.90	3	$2,033.80	24.57%
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	$903.90	0	0	-100.00%

Recommendation: Delete colorectal surgery items 32029, 32220 and 32221.

Rationale

The Committee recommended that item 32029 (construction of a colonic reservoir) be deleted and the service described by this item be included within the descriptors for items 32026 and 32028. Items 32026 and 32028 are both rectal resection procedures used in the treatment of rectal cancer. The construction of a colonic reservoir has been shown to result in improved postoperative functioning of the rectum by decreasing rates of faecal urgency and incontinence (25).

It is recommended that item 32029 be deleted as a separate item for the construction of a colonic reservoir is no longer required if the recommended amendments to the descriptors for items 32026 and 32028 to include 'with or without colonic reservoir' are adopted.

- The fee for the combined item should be set at a value proportional to service volumes for items 32026 and 32029, and 32028 and 32029.

The Committee recommended the deletion of items 32220 and 32221 as artificial bowel sphincters are no longer considered best practice for the treatment of severe faecal incontinence. This is due to the high rates of complications associated with artificial bowel sphincters.

The need for a specific MBS item for the removal or revision of artificial bowel sphincters has become negated as it is presumed that all previously inserted artificial bowel sphincters have now been removed.

4.14.3. Recommendation 37

Table 41: Standard Medicare data for ungrouped colorectal surgery item 32171, 2016/17.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
32171	Anorectal examination, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.)	$88.80	1,176	$76,329.25	1.46%

Recommendation:
Amend the item descriptor for colorectal surgery item 32171.

- The Committee recommended the item descriptor for item 32171 be amended to read:
    - *"Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, not being a service associated with a service to which another item in this Group applies (Anaes.)."*

Rationale

The Committee recommends that the addition of 'with or without faecal disimpaction' to item 32171. Currently, this procedure is included within item 32153, however item 32153 is

recommended for deletion. Additionally, the Committee recommended participating nurse practitioners be able to access to item 32171.

4.15. Peritonectomy

Peritonectomy is a surgical procedure to remove peritoneal mitotic disease. This is most commonly applied to pseudomyxoma peritonei and to peritoneal colorectal cancer, but may also be applied to patients with peritoneal mesothelioma.

Cytoreductive surgery is performed during the peritonectomy to enable removal all the visible tumour within the peritoneal cavity. This may involve resection of a number of organs as well as stripping of wide areas of peritoneum, including subdiaphragmatic, to optimise the ability to remove all disease. Cytoreductive surgery is usually combined with hyperthermic intraperitoneal chemotherapy (HIPEC), which is delivered to the peritoneal cavity during the operation, as a component of the operative procedure, to maximise the likelihood of elimination of all the tumour cells and minimise the risk of recurrence.

Currently, there are no MBS items for peritonectomy. The Committee considered how peritonectomy could best be incorporated into MBS items, particularly in regards to compliance with proposed three item rule.

4.15.1. Recommendation 38

Table 42: Proposed new peritonectomy items recommended for creation.

Item	Descriptor
320MM	Peritonectomy less than 5 hours, including hyperthermic intra-peritoneal chemotherapy.
320NN	Peritonectomy greater than 5 hours, involving multiviscera, including hyperthermic intra-peritoneal chemotherapy.

Recommendation: Create two new peritonectomy items.

Rationale

Peritonectomy and HIPEC is now an established procedure and is undertaken at a limited number of specialist centres (one in each state and two in New South Wales) across Australia. It is now included as part of the current National Health and Medical Research

Council (NHMRC) clinical practice guidelines for the prevention, early detection and management of colorectal cancer (26). The surgery usually involves radical resection of a number of organs as well as removal of areas of peritoneum, with the aim to clear disease (27) (28). While MBS item 30392 exists for debulking of advanced intra-abdominal malignancy and item 35720 for debulking of advanced gynaecological malignancy, there are currently no numbers that represent the extensiveness of peritonectomy surgery.

The Committee recommends the new peritonectomy items are time-based, with time referring to operative time only, not overall theatre utilisation time. This is in view of the wide spectrum of potential individual procedures that can be undertaken in combination (e.g. right hemicolectomy, small bowel resection, anterior resection, abdominal hysterectomy, bilateral oophorectomy, splenectomy, cholecystectomy, peritonectomy [pelvic, flank, right and left subdiaphragmatic], greater and lesser omentectomy, partial gastrectomy), as well as the application of Hyperthermic intraperitoneal chemotherapy (HIPEC) (29) (30) (31). A time-based model is proposed as these procedures hold some similarity to the time-based items for division of adhesions. This is due to the fact that the extent of the operation, with respect to the number of individual procedures required, is proportional to the amount of disease present, and total clearance of the disease present in the abdomen, rather than just debulking of the disease, is essential to ensure optimal outcomes. As the multiple procedures required cannot be included within three numbers only, a time based approach would give a more realistic representation of the workload required for any specific operation.

Excellent outcomes can be obtained from peritonectomy and HIPEC, with the specific outcomes strongly dependent on the tumour type and the extent of disease present. Five year survival for pseudomyxoma peritonei is over 70%, with both low and high volume cases appropriate for surgery. This is in contrast to colorectal cancer, where surgery is restricted to cases with lower disease volume, as commonly measured using the Peritoneal Cancer Index as being disease volume less than 15/39. In these cases, a 5 year survival of 35-40% is attainable, as compared to a 6-12 month overall survival with chemotherapy alone.

Amendment to the Report from the Colorectal Surgery Clinical Committee, 2019. Recommendation 38: This recommendation will be progressed as part of the Report from the General Surgery Clinical Committee of the MBS Review and remains within this Report for information purposes only.

4.16. Pelvic exenteration

Multivisceral resections are performed for advanced primary pelvic malignancies including colorectal and anal cancers, selected gynaecological or urological cancers, as well as recurrent pelvic cancers.

Pelvic exenteration operations vary widely in magnitude from more straight forward, centrally-placed resections (e.g. en bloc resection of a uterus or part of a bladder, at the same time of a rectal or sigmoid cancer resection which could be performed in most larger hospitals) to major exenterations which include resection of the rectum, sphincters, pelvic floor, bladder and prostate or uterus and vagina.

More extensive exenterations may also include the pelvic side wall vasculature as well as lymph nodes and/or bony structures surrounding the pelvis including sacrum, ischium or pubic bones. The complexity of the surgery increases with surgery for recurrent tumours. Major exenterations may typically require nine to 12 hours of operating time, but can take in excess of 16 hours. These patients have an average length of hospital stay between three and four weeks. Major exenterations should be performed in specialist referral centres.

Co-morbidities such as inflammatory bowel disease add further complexity to these procedures.

A subgroup was formed within the Committee to consider how best to address pelvic exenterations in order to develop items which describe a complete medical service. Data was provided by three specialist referral units where such surgeries are performed. A total of 80 cases were provided for analysis of MBS services data. No common theme was deduced due to the high variability of surgeries, heterogeneity in the length of surgery and lack of clear patterns in billing codes.

Surgeons undertaking pelvic exenterations within the data observed all claimed in excess of three MBS items and frequently claimed between 10 and 20 items for the one procedure.

For these reasons, the Committee has proposed twelve new items number for pelvic exenteration based upon the extensiveness of the procedure.

4.16.1. Recommendation 39

Table 43: Proposed new pelvic exenteration items based upon anatomical compartment, for an initial procedure.

Item	Descriptor	Proposed fee
320PP	Pelvic exenteration, initial procedure, involving en bloc soft tissue multivisceral resection (excluding en bloc hysterectomy and colorectal resection) performed at an appropriately resourced major specialist centre.	$3,750.00
320QQ	Pelvic exenteration, initial procedure, involving en bloc bony multivisceral resection performed at an appropriately resourced major specialist centre (excluding coccygectomy, i.e. bony resection should involve en bloc resection of major bony structure such as sacrectomy or resection of pubic bones or ischium).	$3,150.00
320RR	Pelvic exenteration, initial procedure, involving en bloc resection of pelvic side wall major vasculature with nodal tissue, pelvic fascia and or obturator internus muscle performed at an appropriately resourced major specialist centre.	$2,100.00

Recommendation: Create three new items for pelvic exenteration based upon anatomical compartments for initial procedures.

Rationale

The three proposed new items are based upon how extensive the exenteration is in regards to the extent of viscera, bony structure and vasculature involved.

The fees for these items reflect the complexity of the procedure and remuneration is commensurate with expected complexity and its aftercare. The proposed fees for these items were based upon the average of the total fees of each procedure within data provided by three specialist referral units of previous pelvic exenteration procedures.

The Committee raised concerns about possible misuse of these item numbers due to high remuneration. Therefore the proposed new items specify that these procedures should be performed in major specialist referral units.

Major exenterations involve multiple surgeons who should be able to claim these numbers. Currently most major exenterations involve two surgical teams but can involve colorectal surgeons, urologists, vascular surgeons, plastic surgeons and orthopaedic oncologists.

Table 44: Proposed new pelvic exenteration items based upon anatomical compartment, for re-do procedure.

Item	Descriptor	Proposed fee
320SS	Pelvic exenteration for recurrent pelvic cancer, involving en bloc soft tissue multivisceral resection (excluding en bloc hysterectomy and colorectal resection) performed at an appropriately resourced major specialist centre.	$5,250.00
320TT	Pelvic exenteration for recurrent pelvic cancer, involving en bloc bony multivisceral resection performed at an appropriately resourced major specialist centre (excluding coccygectomy, i.e. bony resection should involve en bloc resection of major bony structure such as sacrectomy or resection of pubic bones or ischium).	$4,410.00
320UU	Pelvic exenteration for recurrent pelvic cancer, involving en bloc resection of pelvic side wall major vasculature with nodal tissue, pelvic fascia and or obturator internus muscle performed at an appropriately resourced major specialist centre.	$2,940.00

Recommendation: Create three new items for pelvic exenteration based upon anatomical compartments for re-do procedures.

Rationale

These three proposed new items are pelvic exenteration for patients with a history of recurrent pelvic cancer, where there may have been previous surgery and adjuvant chemotherapy or radiation. These types of surgeries have several factors that may not be present in patients undergoing an initial procedure, including:

- Significantly greater aftercare of approximately 3 to 4 weeks,
- Large amount of time (sometimes several hours) dividing adhesions,
- Higher risk of complications (in the order of 80%).

For these reasons, the proposed fees for items for pelvic exenteration for recurrent pelvic cancer are 40% greater than the proposed fees for initial procedures.

Table 45: Proposed new pelvic exenteration items based upon anatomical compartment, for use by conjoint surgeon in an initial procedure.

Item	Descriptor	Proposed fee
320VV	Pelvic exenteration, initial procedure, involving en bloc soft tissue multivisceral resection (excluding en bloc hysterectomy and colorectal resection) performed at an appropriately resourced major specialist centre, conjoint surgeon.	$2,812.50
320WW	Pelvic exenteration, initial procedure, involving en bloc bony multivisceral resection performed at an appropriately resourced major specialist centre (excluding coccygectomy, i.e. bony resection should involve en bloc resection of major bony structure such as sacrectomy or resection of pubic bones or ischium), conjoint surgeon.	$2,362.50
320XX	Pelvic exenteration, initial procedure, involving en bloc resection of pelvic side wall major vasculature with nodal tissue, pelvic fascia and or obturator internus muscle performed at an appropriately resourced major specialist centre, conjoint surgeon.	$1,575.00

Recommendation: Create three new items for pelvic exenteration based upon anatomical compartments, initial procedure, for use by a secondary surgeon.

Rationale

Most major exenterations involve two surgical teams. Proposed new items 320PP, 320QQ and 320RR are intended to be claimed by the principal surgeon performing the procedure, in cases where it is the patient's initial pelvic surgery. Proposed new items 320VV, 320WW and 320XX mirror those of the principal surgeon, but are intended for use by the secondary surgeon.

The proposed fees for these items carry a comparatively lower fee of 25% lower than that of the principal surgeon. This fee structure is considered to allow for an equitable division of the fees between the principal and secondary surgeon to accommodate for the difficulty associated in remunerating for the aftercare provided by the principal surgeon.

Table 46: Proposed new pelvic exenteration items based upon anatomical compartment, for use by conjoint surgeon in a re-do procedure.

Item	Descriptor	Proposed fee
320YY	Pelvic exenteration for recurrent pelvic cancer, involving en bloc soft tissue multivisceral resection (excluding en bloc hysterectomy and colorectal resection) performed at an appropriately resourced major specialist centre, conjoint surgeon.	$3,937.50
320ZZ	Pelvic exenteration for recurrent pelvic cancer, involving en bloc bony multivisceral resection performed at an appropriately resourced major specialist centre (excluding coccygectomy, i.e. bony resection should involve en bloc resection of major bony structure such as sacrectomy or resection of pubic bones or ischium), conjoint surgeon.	$3,307.50
320ZA	Pelvic exenteration for recurrent pelvic cancer, involving en bloc resection of pelvic side wall major vasculature with nodal tissue, pelvic fascia and or obturator internus muscle performed at an appropriately resourced major specialist centre, conjoint surgeon.	$2,205.00

Recommendation: Create three new items for pelvic exenteration based upon anatomical compartments, re-do procedure, for use by the secondary surgeon.

Rationale

Most major exenterations involve two surgical teams. Proposed new items 320SS, 320TT and 320UU are intended to be claimed by the principal surgeon performing the procedure, in cases where the patient has undergone previous pelvic surgery. Proposed new items 320YY, 320ZZ and 320ZA mirror those of the principal surgeon, but are intended for use by the secondary surgeon.

The proposed fees for these items carry a comparatively lower fee of 25% lower than that of the principal surgeon. This fee structure is considered to allow for an equitable division of the fees between the principal and secondary surgeon to accommodate for the difficulty associated in remunerating for the aftercare provided by the principal surgeon.

Annotation: The MBS Review Taskforce consider the proposed fees for items 320PP, 320QQ, 320PP, 320SS, 320TT, 320UU, 320VV, 320WW, 320XX, 320YY, 320ZZ, and 320ZA to be indicative values only.

Indicative fees were calculated based upon de-identified data provided by three Australian tertiary centres of previously performed pelvic exenteration surgeries. These values are considered to be of comparative value to the combination of MBS items claimed in previous procedures.

5. Impact statement

This section of the report summarises the Committee's recommendations in plain English and is intended to support and encourage consumers to comment on the recommendations.

Both consumers and clinicians are expected to benefit from the Committee's recommendations as they address concerns regarding consumer safety and quality of care and take steps to simplify the MBS to make it easier to use and understand. Consumer access to services was considered for each recommendation. The Committee also considered the impact of each recommendation on provider groups to ensure that 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.

The Committee expects these recommendations will support the provision of appropriate colorectal surgery services that incorporate clinically indicated, high-quality surgical methods and techniques that reflect modern best practice.

The Committee's recommendations regarding access to stomal therapy nursing, ERAS and consumer health literacy, draw attention to, and are intended to initiate change regarding, important consumer health issues for patients who require colorectal surgery.

In recent years, changes have been introduced that allow appropriate patients to be more involved in their preparation for major surgery and post-surgery recovery compared to typical practices. These patients recover faster and return to normal activity sooner. This treatment program, called Enhanced Recovery After Surgery (ERAS) is recommended for wider adoption and this Report seeks to highlight the importance of consumer awareness of this program.

Following a stomosis, patients require after care from stomal therapy nurses, therefore patient access to their services is essential. It is important that consumers are aware of the role of stomal therapy nurses and can ask their surgeon about stomal therapy nurse availability before undergoing surgery.

The Committee's recommendations for the deletion of 16 items are expected to benefit consumers by reducing the overall number of colorectal surgery MBS items, thereby making the MBS simpler and, for providers, more user-friendly. In most cases, recommendations to

delete items relate to procedures that are appropriately performed as an intrinsic part of another procedure. However, where an item is always performed as part of another procedure and there is no other clinical indication for its use as a standalone item, the Committee recommended its deletion. For example, item 32006 for hemicolectomy (removal of part of the bowel) was recommended for deletion as the same service is always performed with either the creation of a stoma (where an opening is made to connect the end of the bowel with the surface of the abdomen) or an anastomosis (where one part of the bowel is connected to another part). Therefore, there is no clinical need for an item for hemicolectomy alone. The services patients receive will not be affected by this change.

Some items are recommended for deletion because the procedure described by the item is no longer considered best practice. In these instances, the Committee recommended the deletion of services based upon patient safety concerns. For example, the Committee recommended the deletion of items for graciloplasty, a procedure in which a muscle from the inner thigh is surgically moved to the anus as a treatment for faecal incontinence. Deletion of graciloplasty items is recommended because this is no longer considered the best way of surgically treating patients with faecal incontinence and may be associated with pain and other complications. Patients will benefit from this change because the best services, according to recent clinical evidence, will be available on the MBS.

The new services recommended by the Committee are intended to reflect surgical techniques not previously covered by the MBS. These are for procedures that are already being performed and there is good evidence that they have the best outcomes for patients. Having specific item numbers for these new surgical procedures provides better transparency when billing the consumer because the service will be properly described by the relevant item number, rather than using an item number for the equivalent older service. The new items will also provide more appropriate Medicare rebates which are expected to reduce the out-of-pocket costs to consumers associated with these procedures.

Some of the new items recommended by the Committee are for complex surgeries which previously were performed but were billed under a variety of ‘best fit’ items. Now they have their own Item descriptor and number. This will benefit patients as it will improve the consistency of billing across providers and make it clearer to the patient what service they have received.

Additional recommendations to amend the descriptors of items and to combine items that provide a similar service, will help to create a much simpler colorectal surgery portion of the MBS that more accurately describes current best clinical practice.

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7. Glossary

Term	Description
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).
CSSANZ	Colorectal Surgical Society of Australia and New Zealand
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
DHS	Australian Government Department of Human Services
FAP	Familial adenomatous polyposis
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.
IBD	Inflammatory bowel disease
HIPEC	Hyperthermic intraperitoneal chemotherapy
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.
MIS	Minimally invasive surgical approach
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.
MSAC	Medical Services Advisory Committee
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.
NHMRC	National Health and Medical Research Council
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.
PBS	Pharmaceutical Benefits Scheme
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).
taTME	Transanal total mesorectal excision

The Committee	The Colorectal Surgery Clinical Committee of the MBS Review
The Taskforce	The MBS Review Taskforce
TME	Total mesorectal excision
Total benefits	Total benefits paid, data relates to the 2016/17 financial year, unless otherwise specified.

Appendix A: Summary for consumers

The following tables describe the colorectal surgery service, the recommendations of the clinical experts and why the recommendations have been made.

Access to stomal therapy nurses

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
32025, 32026 and 32028	Procedures involving the creation of a stoma.	That these items include an Explanatory Note to say that they should be performed in a place with enough access to stomal therapy nurses.	This would help to ensure that when a patient has a procedure that creates a stoma, that there is access to a qualified nurse to assist the patient to manage their stoma. This will improve patient equity by promoting the same level of access for all patients.	Currently there are areas around Australia where patients may not be able to access stomal therapy nurses. Not being able to see a stomal therapy nurse can cause stress to patients. Including an Explanatory Note for some surgical items will help to ensure that consideration is given to patient access to stomal therapy services.

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	That additional consideration is given to creating items that could be claimed by stomal therapy nurses to provide care to people living with a stoma.	Consideration may be given to the creation of a new MBS item for stomal therapy services that could be claimed by stomal nurses. This would help improve access to these services for patients.	Stomal therapy nurses hold additional qualifications and can help people living with a stoma with initial and ongoing adjustment to, and management of their stoma, including improved wound care.

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
	N/A	That the Australian Government considers what other changes could be made to help improve access to stomal therapy nurses.	It is recommended that more consideration be given to this issue. Greater access to stomal therapy nurses will assist in improving health outcomes, enabling return to work and resumption of lifestyle for people living with a stoma. It will also provide benefit through the reduction of personal and social costs associated with treatment for bowel conditions.	Stomal therapy nurses provide specialist care to people living with a stoma. The Committee recommends that consideration be given to creating MBS items for use by stomal therapy nurses but also recommends that broader consideration be given to how the MBS can reflect the work of stomal therapy nurses and improve patient access to these services.

Enhanced recovery after surgery

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
32000, 32003, 32004, 32005, 32009, 32012, 32015, 32018, 32021, 32024, 32025 and 32026	Enhanced recovery after surgery (ERAS) is a set of principles that aim to reduce the physical stress of surgery, maintain physical function and help patients to be mobile again soon after surgery.	That these items should include an Explanatory Note about ERAS.	For these surgeries, there would be an Explanatory Note on the item to say that patients should be managed by ERAS principles whenever possible.	ERAS principles help patients to recover more quickly which means they do not need to stay in hospital for as long, can eat and drink soon after surgery, and can return to their normal activities sooner than might otherwise be possible.

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
N/A		That all other suitable surgeries should include Explanatory Notes about ERAS.	Colorectal, orthopaedic, urology and pancreatic surgeries would include an Explanatory Note to say that patients should be managed by ERAS principles whenever possible.	ERAS principles help patients to recover more quickly which means they do not need to stay in hospital for as long, can eat and drink soon after surgery, and can return to their normal activities sooner than might otherwise be possible.

Consumer health literacy

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
N/A	Supports a recommendation to improve the ability of consumers to make decisions about their health by improving health education.	Supports a recommendation from another clinical committee of the MBS Review regarding consumer health literacy.	Patient education, through discussion of treatment options and written materials, would be included for a number of MBS items.	It is important that consumers are well supported to make educated decisions about their health. Educational materials can help patient understanding and ensure that information is remembered correctly. Treatment options should always be discussed to allow patients to give informed consent before undergoing any procedure.

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
N/A	Endorses clinical practice in line with the Royal College of Surgeons.	Endorses that best practice is in line with the Royal College of Surgeons' position on informed patient consent.	Helps to ensure that surgeons always follow best practice in regards to informed consent.	Surgeons should discuss the nature of the patient's illness or disease, the diagnosis, proposed treatment and any other options for treatment. This helps consumers understand the risks and outcomes for any procedure and to make their own informed decisions.

Recommendation

Item	What it does	Committee recommendation	What would be different	Why
N/A	Looks to increase consumer education before undergoing colorectal surgery.	Encourages the use of education materials available from the Colorectal Surgical Society of Australia and New Zealand on many colorectal procedures.	Helps increase patient understanding prior to undergoing surgery.	It is important that consumers are well supported to make educated decisions about their health. Educational materials can help patient understanding and ensure that information is remembered correctly. Treatment options should always be discussed to allow patients to give informed consent before undergoing any procedure.

Hemicolectomy, total colectomy, and rectal resection

Recommendation 1

Items	What it does	Committee recommendation	What would be different	Why
32000, 32003, 32009, 32012 and 32015	Removal of either part (hemicolectomy) or all (total colectomy) of the large bowel or rectum (rectal resection). This may involve the creation of a stoma, which is when part of the large bowel is brought up to an opening onto the abdomen to allow the passage of stool into a colostomy bag. These procedures are most often done for the treatment of bowel cancer, diverticulitis, polyps or inflammatory bowel disease.	Leave five items for hemicolectomy, total colectomy and rectal resection unchanged.	There would be no change to the current items.	The current items reflect best practice and do not need to be changed.

Recommendation 2

Items	What it does	Committee recommendation	What would be different	Why
32006	Removal of the left part of the bowel (left hemicolectomy).	Change the descriptor for this item to restrict co-claiming with certain other items.	Surgeons would no longer be able to claim this item at the same time as the procedures described under items 32024, 32025, 32026 and 32028.	The way these operations are performed has evolved over time and co-claiming these items at the same time is no longer necessary.

Recommendation 3

Items	What it does	Committee recommendation	What would be different	Why
32004 and 32005	Removal of a large portion, but not all, of the large bowel. This can be done either with or without the formation of an anastomosis (where the cut end of the bowel is joined up with another part of the bowel).	The descriptors be changed to add a restriction that says the items cannot be claimed at the same time as item 32030.	When a surgeon performs an operation to remove most of the large bowel, they will only be able to claim one of these items and not item 32030. The procedure itself would not change.	It would be inappropriate to claim these items together as they cover similar procedures. Consumers will not be affected by the change.

Recommendation 4

Items	What it does	Committee recommendation	What would be different	Why
32024, 32025, 32026, 32028, 32030 and 32033	Removal of part of the rectum (the lowest part of the large bowel) with or without the creation of an anastomosis (a surgical connection that joins the cut end of the bowel to another part of the bowel) and with or without the formation of a stoma (where the bowel is connected to the abdominal wall so that it opens onto the outside of the abdomen and the stool is collected in a specialised stoma bag).	That the descriptors for items 32024 and 32025 be changed so that they cannot be claimed at the same time as (co-claimed) with items 32000 or 32030. It is also recommended that item 32026 be amended so the item cannot be co-claimed with items 32000, 32030, 32103, 32104, 32106 and 32117. It is also recommended Explanatory Notes be added to these items to guide appropriate use.	When these procedures are performed, the surgeon would not be able to claim the items at the same time as other items where co-claiming has been restricted. The procedure itself would not change.	The changes would ensure the appropriate procedure is claimed for the circumstances. The addition of Explanatory Notes will help guide the way the procedures are performed (e.g. at an appropriate facility and with the appropriate post-operative support).

Synchronous surgeries

Recommendation 5

Item	What it does	Committee recommendation	What would be different	Why
32018 and 32021	Removal of the large bowel and rectum with formation of an ileostomy (where the last part of the small bowel is connected to the abdominal wall and an opening formed), performed by two surgeons where one operates from the abdomen and one operates from the bottom (perineal) end.	Leave the current two items unchanged.	There would be no change to the current items.	The current items reflect best practice and do not need to be changed.

Recommendation 6

Item	What it does	Committee recommendation	What would be different	Why
32042 and 32045	Removal of part of the rectum and anus performed by two surgeons where one operates from the abdomen and one operates from the perineal end.	Leave the current two items unchanged.	There would be no change to the current items.	The current items reflect best practice and do not need to be changed.

Recommendation 7

Item	What it does	Committee recommendation	What would be different	Why
32046	Removal of part of the rectum and anus performed by two surgeons where one operates from the abdomen and one operates from the perineal end where the perineal surgeon provides assistance to the abdominal surgeon.	Leave the current item unchanged.	There would be no change to the current item.	The current item reflect best practice and does not need to be changed.

Recommendation 8

Item	What it does	Committee recommendation	What would be different	Why
32054 and 32057	Removal of the large bowel, including the rectum when done by two surgical teams operating at the same time. Item 32054 can be claimed by the surgeon operating from the abdomen and item 32057 can be claimed by the surgeon operating from the perineal end.	Leave the current two items unchanged.	There would be no change to the current items.	The current items reflect best practice and do not need to be changed.

Recommendation 9

Item	What it does	Committee recommendation	What would be different	Why
32063 and 32066	Closure of an ileostomy (where part of the small bowel is connected to a hole in the abdominal wall) with removal of part of the rectum. The procedure also involves connection of the end of the ileum (part of the small bowel) to the anus, with or without the formation of a pouch designed to hold stool, called an ileal reservoir. These items are for surgeries with two surgeons where the abdominal surgeon claims item 32063 (which includes responsibility for the aftercare required following the operation) and the perineal surgeon claims item 32066.	Leave the current two items unchanged.	There would be no change to the current items.	The current items reflect best practice and do not need to be changed.

Recommendation 10

Item	What it does	Committee recommendation	What would be different	Why
320AR, 320TC, 320HP and 320PC	Proposed new transanal total mesorectal excision (taTME) items for the following: Low or ultra-low resection of the rectum (where part of the rectum is removed and the end part of the resected bowel is attached to the anus). Restorative proctocolectomy, a surgical procedure to remove part of the colon and rectum while preserving continence. Abdomino-perineal resection, a surgical procedure where part of the colon, the rectum and the anal sphincter are removed through incisions made in the abdomen and the perineal region for the removal of a rectal cancer. Pan-proctocolectomy is the surgical removal of the entire colon, rectum and anal canal.	That four new items be created for the abdominal component of a low or ultra-low resection of the bowel, restorative proctocolectomy, abdomino-perineal resection and pan-proctocolectomy that include taTME principles.	There would be MBS items for each of these surgical procedures that includes technologies to provide the operating surgeons with improved visualisation of the area. These surgeries are often performed by two surgeons working together and these items are intended for use by the abdominal surgeon.	TaTME methods provide advantages to some patients, such as male patients with a narrow pelvis and/or patients with a tumour located close to the pelvic floor/sphincter.

Item	What it does	Committee recommendation	What would be different	Why
320ST, 320HS and 320EA	Proposed new transanal total mesorectal excision (taTME) items for the following: Low or ultra-low resection of the rectum (where part of the rectum is removed and the end part of the resected bowel is attached to the anus). Restorative proctocolectomy, a surgical procedure to remove part of the colon and rectum while preserving continence. Abdomino-perineal resection, a surgical procedure where part of the colon, the rectum and the anal sphincter are removed through incisions made in the abdomen and the perineal region for the removal of a rectal cancer. Pan-proctocolectomy is the surgical removal of the entire colon, rectum and anal canal.	That three new items be created for the perineal component of a low or ultra-low resection of the bowel, restorative proctocolectomy, abdomino-perineal resection and pan-proctocolectomy that include taTME principles.	There would be MBS items for each of these surgical procedures that includes technologies to provide the operating surgeons with improved visualisation of the area. These surgeries are often performed by two surgeons working together and these items are intended for use by the perineal surgeon.	TaTME methods provide advantages to some patients, such as male patients with a narrow pelvis and/or patients with a tumour located close to the pelvic floor/sphincter.

Abdominoperineal resection – single surgeon

Recommendation 11

Item	What it does	Committee recommendation	What would be different	Why
32039	Removal of part of the large bowel, rectum and anal sphincter, using both abdominal and perineal incisions. Performed for the treatment for rectal cancer.	Leave item unchanged.	There would be no change to the current item.	The current items reflect contemporary best practice and do not need to be changed.

Proctocolectomy and ileal pouches

Recommendation 12

Item	What it does	Committee recommendation	What would be different	Why
32051 and 32069	Item 32051 is for removal of the entire large bowel with construction of a pouch from the end of the small intestine to the anus to allow for normal passage of stool. Item 32069 is for construction of the pouch alone.	Leave two items for proctocolectomy and ileal pouch unchanged.	There would be no change to the current items.	The current items reflect current best practice and do not need to be changed.

Recommendation 13

Item	What it does	Committee recommendation	What would be different	Why
32060	Removal the entire colon and rectum when the anal sphincter is left intact and a pouch, or internal reservoir, is created that allows for normal bowel function.	That the descriptor be amended to better describe the procedure.	The descriptor for the item will more accurately reflect the procedure. Consumers will not be affected by the changes.	Changing the descriptor will reduce confusion with other similar procedures.

Rectal tumours

Recommendation 14

Item	What it does	Committee recommendation	What would be different	Why
32108	Surgical removal of a rectal tumour.	Leave item unchanged.	There would be no change to the current item.	The current item reflects contemporary practice and does not need to be changed.

Recommendation 15

Item	What it does	Committee recommendation	What would be different	Why
32105	Surgical removal of an anorectal tumour (a tumour in the anus and rectum).	Delete the item.	The item would be removed from the MBS. Consumers will not be affected by the changes.	There are a number of other items that could be claimed for removal of an anorectal tumour and this item is considered unnecessary.

Recommendation 16

Item	What it does	Committee recommendation	What would be different	Why
32099 and 32102	Surgical removal of rectal tumour. Item 32099 is for tumours 5cm in diameter or less and item 32102 is for tumours greater than 5cm in diameter.	Combine these two items into one item that does not specify tumour size.	One item would exist for rectal tumour removal instead of two separate items for tumours of different sizes. Consumers will not be affected by the changes.	Currently the two items are separated depending upon the size of the tumour. It is recommended the two items be combined into one item, with no reference to tumour size and should be used for the removal of smaller tumours. Larger tumours should be removed using a more appropriate procedure.

Recommendation 17

Item	What it does	Committee recommendation	What would be different	Why
32096	Rectal biopsy (a procedure to remove a small piece of tissue for the rectum in order to perform laboratory testing on the sample obtained).	The descriptor of this item should be changed to include the diagnosis of Hirschsprung's disease (a condition where nerve cells are missing from the large bowel) in the reasons for doing the test.	The item descriptor would be changed to say that this procedure is done to diagnose or exclude Hirschsprung's disease. Consumers will not be affected by the changes.	This procedure is usually performed to test the tissue of the large bowel for the presence of nerve cells. The absence of nerve cells in the rectum is associated with a condition called Hirschsprung's disease. Including this in the item descriptor would more accurately inform patients about why the test is being performed.

Recommendation 18

Item	What it does	Committee recommendation	What would be different	Why
32103, 32104 and 32106	Removal of rectal tumours that cannot be removed during colonoscopy using digital optic viewing systems that allow the surgeon to get a better look at the area.	Combine items 32103 and 32104 into one item and change the descriptor for item 32106.	The items would be updated with current technology and the reference to tumour size in items 32103 and 32104 would be removed. Consumers will not be affected by the changes.	Changes to these items will not affect patients but will more accurately describe what technology is being used for removal of the tumour.

Rectal prolapse

Recommendation 19

Item	What it does	Committee recommendation	What would be different	Why
32123 and 32131	Item 32123 is repair of a narrowing of the anal canal. Item 32131 is for the repair of weakened tissues of the rectum that have caused the rectum to bulge into the vagina.	Leave the current items unchanged.	There would be no change to the current items.	The current items reflect contemporary best practice and do not need to be changed.

Recommendation 20

Item	What it does	Committee recommendation	What would be different	Why
32120 and 32126	Item 32120 is for repair of rectal prolapse (when part of the bowel has collapsed and may protrude from out from the anus). Item 32126 describes a surgical procedure to treat accidental leakage of stool and an inability to control bowel movements.	These items should be deleted.	These items would be removed from the MBS and other items would be used for these treatments. Consumers will not be affected by the changes.	These items are for procedures that are no longer performed, or are more accurately described by another item.

Recommendation 21

Item	What it does	Committee recommendation	What would be different	Why
32111 and 32112	Repair of rectal prolapse (when part of the bowel has collapsed and may protrude out from the anus).	Combine these two items into one item.	One item would now be used for repair of rectal prolapse. Consumers will not be affected by the changes.	There is no need for both of these items.

Recommendation 22

Item	What it does	Committee recommendation	What would be different	Why
32114 and 32115	Treatments for rectal stricture (narrowing of the anal canal, which can make passage of stool difficult). Item 32114 is for surgical release and item 32115 is for dilatation of the rectum.	Combine these two items into one item.	One item would now be used for the treatment of rectal stricture by any method instead of two separate items for different methods. Consumers will not be affected by the changes.	There are a number of procedures that may be used to treat narrowing of the rectum. These two items are similar and combining them into one would simplify the MBS.

Recommendation 23

Item	What it does	Committee recommendation	What would be different	Why
32117	Repair of rectal prolapse, which is when part of the bowel has collapsed and may protrude out from the anus. This item is used when the repair is performed through the abdomen.	Change the descriptor for this item to restrict co-claiming with certain other items.	Surgeons would no longer be able to claim this item at the same time as procedures to remove significant sections of the bowel.	Sometimes part of the bowel may be removed when a rectal prolapse is repaired through the abdomen. However it would not be appropriate to remove larger sections of the bowel at the same time as doing this procedure. Therefore, the item should include restrictions on doing these procedures at the same time.

Recommendation 24

Item	What it does	Committee recommendation	What would be different	Why
32129	Repair of the anal sphincter which may have been damaged as a result of injury.	Change the descriptor for this item to make it simpler.	Unnecessary words would be removed from the descriptor.	A minor change is recommended to simplify the description for this item.

Recommendation 25

Item	What it does	Committee recommendation	What would be different	Why
320LL	A new item to repair rectal prolapse (when part of the bowel has collapsed and may protrude out from the anus). This procedure uses a minimally invasive technique called ventral rectopexy, which takes longer to perform than traditional methods.	That a new item be created for the repair of rectal prolapse using the surgical technique called ventral rectopexy.	There would now be an item that surgeons can use specifically for this procedure.	Ventral rectopexy is already widely performed and is considered the preferred surgical method for the treatment of rectal prolapse. Having an item specifically for this procedure will more accurately indicate to consumers what procedure is being performed.

Haemorrhoids, fistulae and abscesses

Recommendation 26

Item	What it does	Committee recommendation	What would be different	Why
32147, 32159, 32162, 32066, 32174 and 32175	Surgical treatments for haemorrhoids, anal fistulae and drainage of anal abscesses.	Leave six items for haemorrhoids, anal fistula and drainage of anal abscesses unchanged.	There would be no change to the current items.	The Committee agreed the current items reflect contemporary best practice and do not need to be changed.

Recommendation 27

Item	What it does	Committee recommendation	What would be different	Why
32132, 32138, 32153 and 32168	Treatments for different anal conditions. Item 32132 is for the treatment of haemorrhoids using a technique called sclerotherapy which involves the injection of a solution into a haemorrhoid. Item 32138 is for the surgical removal of haemorrhoids, including anal skin tags. Item 32153 is for dilatation of the anus under general anaesthetic and item 32168 is for the review of a fistula wound (an abnormal connection between two hollow spaces).	Delete these items	These items would no longer exist on the MBS.	There are other items that describe these procedures and should be claimed in place of these items. There are no other clinical reasons to keep these items. Therefore, it is unnecessary to keep the items on the MBS.

Recommendation 28

Item	What it does	Committee recommendation	What would be different	Why
32142 and 32145	Removal of anal skin tags or polyps. Item 32145 is for the procedure when undertaken in an operating theatre or hospital.	Combine these two items into one item.	One item would exist for the removal of anal skin tags or polyps instead of two.	Currently these items are separated depending on whether the procedure is performed in an operating theatre or not. This distinction is unnecessary and the fee for this procedure should be the same regardless of where it is performed.

Recommendation 29

Item	What it does	Committee recommendation	What would be different	Why
32177 and 32180	Removal of anal warts. Item 32177 is for procedures of 45 minutes duration or less and item 32180 is for procedures lasting more than 45 minutes.	Combine these two items into one item.	One item would exist for the removal of anal warts instead of two separate item for surgeries of different durations.	Currently these two items are separated depending on how long the procedure takes to perform. It is not considered best practice to take a long time to remove anal warts as extensive wart removal may become uncomfortable for the patient. Therefore only one item is needed for removal of anal warts with no reference made to the length of the procedure.

Recommendation 30

Item	What it does	Committee recommendation	What would be different	Why
32135, 32139, 32150, 32156 and 32165	Surgical treatments for haemorrhoids or anal fistulae. Item 32135 is for the removal of haemorrhoids using a rubber band or other techniques. Item 32139 is for the surgical removal of haemorrhoids which protrude out through the anus. Item 32150 is for the repair of an anal fissure (a break or tear in the skin of the anus). Item 32156 is for the repair of an anal fistula (an abnormal connection between two hollow spaces) and item 32165 is for the repair of an anal fistula using a technique called mucosal flap advancement.	Minor changes should be made to the descriptors of these items to correct outdated wording or to simplify the items.	The descriptors for the removal of haemorrhoids procedures would be simplified so that one item is used for non-surgical treatment and the other is used for surgical treatment. The descriptors for items for treatment of anal fistulae would be updated to reflect current practice.	Updating the descriptors of these items will better describe modern practice.

Graciloplasty

Recommendation 31

Item	What it does	Committee recommendation	What would be different	Why
32200, 32203, 32206 and 32209	A procedure where a muscle from the inner thigh is surgically wrapped around the anus. This is performed for the treatment of faecal incontinence (the inability to control bowel movements).	These four items should be deleted.	No items for this procedure would exist on the MBS.	This surgery is no longer considered best practice as it carries considerable risk of patient complications. There are newer procedures that should be used to treat faecal incontinence in place of these procedures.

Sacral nerve lead items

Recommendation 32

Item	What it does	Committee recommendation	What would be different	Why
32210, 32214 and 32217	A treatment for faecal incontinence where a stimulator is inserted into the lower back and an electrical current is used to stimulate a nerve that helps control bowel function.	That these three items should be combined into one item and the descriptor for the new item is amended.	There would be one item for placement of the stimulator. Also, the descriptor would be changed to allow access for a broader group of patients.	There is now more evidence for the benefits of this treatment than there was when it was originally listed on the MBS in 2005. It is appropriate that more patients will now be able to receive sacral nerve treatment and the item descriptor should be amended to reflect modern practice.

Recommendation 33

Item	What it does	Committee recommendation	What would be different	Why
32213, 32215, 32216 and 32218	These procedures are for the insertion, adjustment or removal of the stimulator or leads used in sacral nerve stimulation for the treatment of faecal incontinence.	That the descriptors of these items are updated.	Previous restrictions on who is eligible for this treatment will be removed.	There is now more evidence for the benefits of this treatment than there was when it was originally listed on the MBS in 2005. It is appropriate that more patients will now be able to receive sacral nerve treatment and the item descriptor should be amended to reflect modern practice.

Diagnostic item

Recommendation 34

Item	What it does	Committee recommendation	What would be different	Why
11833	Assesses the health of the muscles and nerves of the pelvic floor.	This item should remain unchanged.	There would be no change.	The Committee agreed the item reflects contemporary best practice and does not need to be changed.

Ungrouped colorectal surgery items

Recommendation 35

Item	What it does	Committee recommendation	What would be different	Why
32036, 32047, 32183, 32186 and 32212	Different colorectal procedures.	Leave five items for colorectal surgery unchanged.	There would be no change to the current items.	The Committee agreed the current items reflect current best practice and do not need to be changed.

Recommendation 36

Item	What it does	Committee recommendation	What would be different	Why
32029, 32220 and 32221	Item 32029 is a procedure that creates an internal pouch that allows for the storage of stool for normal bowel function. Items 32220 and 32221 are procedures to insert or remove an artificial bowel sphincter (an implant that functions like the anal muscle to manage faecal incontinence).	That these items are deleted.	These items would no longer be listed on the MBS.	The creation of a pouch is often performed as part of surgeries to remove the rectum. It is recommended that the item for pouch creation should be incorporated items for rectal removal. This will increase clarity for consumers. The use of artificial bowel sphincters is no longer considered best practice as there is a high rate of complications associated with the procedure. There are other procedures that are preferred in the surgical treatment of faecal incontinence.

Recommendation 37

Item	What it does	Committee recommendation	What would be different	Why
32171	Internal examination of the rectum.	The descriptor of this item should be changed.	This procedure should now include an option for faecal disimpaction (the manual removal of stool that cannot otherwise be passed).	Faecal impaction is currently included in another item, which is now recommended for deletion. It is appropriate to include it as part of a rectal examination.

Peritonectomy

Recommendation 38

Item	What it does	Committee recommendation	What would be different	Why
320MM, 320NN	Treatment for cancers involving the peritoneal cavity. These include pseudmyxoma peritonei, appendiceal cancer, colorectal cancer and peritoneal mesothelioma. It may also be used for some other forms of cancer. Peritonectomy is the surgical removal of the cancer and the use of chemotherapy directly to the abdomen.	Create two new items for peritonectomy with hyperthermic intraperitoneal chemotherapy (where chemotherapy drugs are injected directly into a tumour).	There would be items that can be used specifically for this surgery.	Currently there are no items for peritonectomy so surgeons claim a combination of other items for this procedure. The use of peritonectomy with hyperthermic intraperitoneal chemotherapy has been shown to provide excellent clinical outcomes for patients depending on type of tumour and extent of disease. Creating items for this procedure will help to improve patient access and treatment outcomes.

Pelvic exenteration

Recommendation 39

Item	What it does	Committee recommendation	What would be different	Why
320PP, 320QQ and 320RR	Exenteration surgery is performed for advanced cancers in the pelvis including colorectal and anal cancers, selected gynaecological or urological cancers, as well as recurrent pelvic cancers. This procedure involves the removal of all of the organs affected by the cancer from the pelvis.	The creation of three new items for exenteration surgery.	There would be three items that could be claimed for exenteration surgery based upon how much disease is present and how much surgery is required.	Currently there are no items for exenteration so surgeons claim a combination of other items for this procedure.