Medicare Benefits Schedule Review Taskforce

Report from the Intensive Care and Emergency Medicine Clinical Committee

2017

Important note

The views and recommendations in this Review report from the Clinical Committee have been released for the purpose of seeking the views of stakeholders.

This report does not constitute the final position on these items which is subject to:

- Stakeholder feedback;

Then

- Consideration by the MBS Review Taskforce;

Then *if endorsed*

- Consideration by the Minister for Health; and
- Government.

Stakeholders should provide comment on the recommendations via the online consultation tool.

Confidentiality of comments:

If you want your feedback to remain confidential, please mark it as such. It is important to be aware that confidential feedback may still be subject to access under freedom of information law.

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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 in order to improve health outcomes for patients. The Taskforce also seeks to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on the following 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 Taskforce has asked the Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items that are obsolete and should be removed from the MBS.
2. Consider identified priority reviews of selected MBS services.
3. Develop a program of work to consider the balance of MBS services within its remit and items assigned to the Committee.
4. Advise the Taskforce on relevant general MBS issues identified by the Committee in the course of its deliberations.

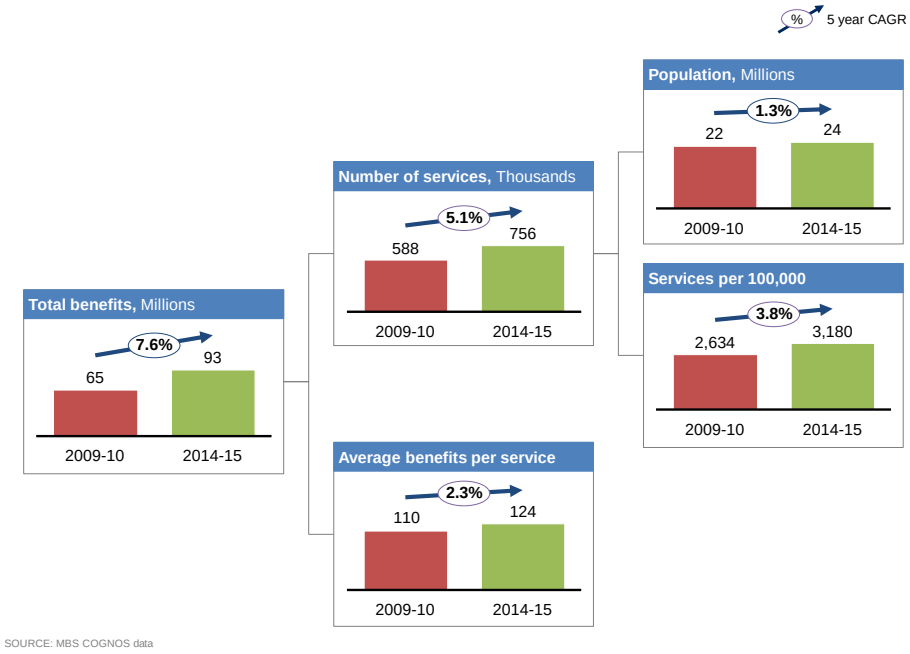
The Intensive Care and Emergency Medicine Clinical Committee (the Committee) was established in June 2016 to make recommendations to the Taskforce regarding MBS items in its area of responsibility, based on clinical expertise and rapid evidence review. The Taskforce asked the Committee to review 29 items related to intensive care and emergency medicine. All recommendations relating to these items are included in this report for consultation.

1.1 Areas of responsibility of the Intensive Care and Emergency Medicine Clinical Committee

The Committee was assigned 29 MBS items to review, covering attendance and procedural services related to emergency medicine and intensive care. A complete list of these items can be found in the Appendix A - Index of items.

In the 2014/15 financial year (FY), these items accounted for approximately 760,000 services and $93 million in benefits. Over the past five years, service volumes for these items have grown at 5.1 per cent per year, and the cost of benefits has increased by 7.6 per cent per year. This growth is largely explained by a 3.8 per cent increase per year in services per head of population (Figure 1).

Figure 1: Drivers of growth



SOURCE: MBS COGNOS data

1.2 Key recommendations

The Committee has highlighted its most important recommendations below. Of the 29 existing items allocated to the Committee for review, 17 were found to require change or deletion. The majority of recommendations involve revising or restructuring items, and two items have been recommended for removal from the MBS. The Committee has also made recommendations for the Medical Services Advisory Committee (MSAC) to conduct an expedited review regarding the inclusion of new items on the MBS.

The complete recommendations and accompanying rationales for all items can be found in Sections 4 to 6. A complete list of items, including the nature of the recommendations and the page number for each recommendation, can be found in Appendix A - Index of items. These recommendations are provisional and may be revised based on feedback received during consultation.

The recommendations focus on the objectives of the MBS Review: improve access to medical services, encourage best practice, increase value for consumers and the health system, and simplify the MBS to improve both patient and provider experience (for example, through improved transparency around services billed), as well as the efficiency with which the MBS is administered.

Section 4 – Emergency medicine recommendations

- Δ Restructure Emergency Department (ED) attendance items (501–536) into three tiered base items with add-on items.
  - The three tiered base items reflect the differing levels of professional involvement required during emergency attendances, based on the number of differential diagnoses and comorbidities that require consideration.
  - The add-on items reflect the significant additional professional involvement associated with issues or tasks that may be performed in an ED context, but that are not a standard component of any particular base item. Specifically, these items cover resuscitation (for half an hour to one hour, one to two hours, or two hours or more), anaesthesia, minor

procedures, procedures, fracture / dislocation management excluding aftercare, fracture / dislocation management including aftercare, care for patients above the age of 75 or below the age of two, chemical or physical restraints, and goals of care. Other MBS items should not be used for services (or components of services) provided in the course of an ED attendance (i.e., the proposed add-on items should be used instead of all existing MBS procedural items).

This recommendation focuses on ensuring that ED attendance items accurately reflect the key patient complexity factors that determine the amount of provider skill, time and risk involved. It does so by making the item descriptors clearer, which will provide patients with greater billing transparency, reduce variability in item use for similar services and support ease of auditing.

- Use a consistent item framework for all emergency attendances, regardless of the provider type. Item descriptions for professional attendances in accredited private EDs should specify the provider type and applicable schedule fee but should otherwise be the same.
  - A lower MBS benefit should apply if the provider is not an Emergency Medicine Specialist. This 'scaled access' to emergency attendance items should provide a fixed proportion of the benefit available for services provided by Emergency Medicine Specialists.

  This recommendation focuses on improving billing transparency for patients and providers, by ensuring the item billed reflects the nature of the service provided.

Section 5 – Intensive care recommendations

- Leave items relating to daily management of a patient in an Intensive Care Unit (ICU; items 13870 and 13873) and invasive pressure monitoring (item 13876) unchanged.

  This recommendation reflects the Committee's view that these items are functioning as intended, and that item 13876 remains an accurate and appropriate scalable surrogate for the complexity of patients in an ICU.

- Remove the differential fees for the first day (item 13847) and subsequent days (item 13848) of managing counterpulsation by intraaortic balloon.

  This recommendation simplifies the MBS and is intended to enhance value for the patient and the health system, recognising that there is no significant difference in the professional involvement required between first and subsequent days of care.

- Consider an expedited MSAC assessment for listing MBS items for extracorporeal life support, and revise items 13851 and 13854 to clarify that they are intended to cover ventricular assist devices (VADs).

  This recommendation focuses on addressing ambiguity in the current item descriptors for items 13851 and 13854, and on supporting access to best-practice health services.

- Revise the item descriptions for item 13815 (central vein catheterisation) and item 13842 (intra-arterial cannulation) to encourage ultrasound guidance where clinically appropriate. Where used, ultrasound guidance should not attract payment of benefits separate to those for items 13815 and 13842.

  This recommendation focuses on supporting best-practice health services and ensuring value for the patients and the community.

- Introduce an MBS item for the discussion and documentation of goals of care by an Intensive Care Specialist. This service is for patients potentially nearing end of life, where alternatives to active management may be an appropriate clinical choice, and where relevant goals of care do

not already exist. (See the proposed item descriptor in Section 5.6 for the appropriate clinical indications, required service components and restrictions on use for this item.)

This recommendation focuses on supporting access to best-practice decision-making services, with the aim of improving both the patient experience and enhancing value for the patient and the health system. The Committee noted that in ideal circumstances, goals of care are defined with a provider who is familiar with the patient, prior to admission to hospital or an ICU. However, if this has not occurred, it is important that patients (and, where relevant, family and carers) receive support to make informed choices prior to embarking on intensive and potentially prolonged treatment.

Section 6 – General recommendations

- Δ Remove obsolete item 14200 (relating to the practice of gastric lavage in the treatment of ingested poison) from the MBS.
- Δ Consider an expedited MSAC assessment for listing an MBS item for rapid response system / code blue attendances. This service is for attendances outside of EDs and ICUs by the medical practitioner taking overall responsibility for the patient in the course of the call or code response. It is not claimable in conjunction with ED attendance or ICU daily management items by the same provider.

  This recommendation focuses on supporting access to this best-practice health service. It recognises that such attendances require a higher level of professional involvement than other referred attendances because the patient is either unstable or critically ill, and because the provider is unfamiliar with the patient and must attend immediately.

1.3 Consumer engagement

The Committee's membership includes a consumer representative. The Committee recommendations have been summarised for consumers in Appendix B including a full list of all the items and their accompanying recommendations. The summary describes the medical service, the recommendation of the clinical experts and why the recommendation has been made for all major changes and proposed new items.

Importantly however, the Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations – and how, and why. Following the public consultation the Committee will assess the advice from consumers and decide whether any changes are needed to the recommendations.

The Committee will then send the recommendations to the MBS Taskforce. The Taskforce will consider the recommendations as well as the information provided by consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendation to government.

1.4 Key consumer impacts

This section summarises the report's key recommendations from a consumer perspective. It aims to make it easier for health consumers and members of the general public to understand and comment on the report's recommendations.

The Committee examined how well descriptions of the 29 MBS items matched current clinical practice and met the needs of Australians. The Committee brought together practitioners with experience in and commitment to the provision of emergency medicine and intensive care services, including Emergency Medicine and Intensive Care Specialists, as well as a Geriatrician and a

Consumer Representative. All recommendations are provisional and may be revised based on feedback received during consultation.

The Committee made three recommendations that aim to improve consumer access to best-practice health services and the consistency with which existing services are delivered in line with best practice:

- Revise the item descriptions for intra-arterial cannulation (item 13842) and central vein catheterisation (item 13815) to encourage use of ultrasound guidance.

  Cannulation and catheterisation of arteries or veins is a procedure that involves inserting a tube ('catheter' or 'cannula') into a blood vessel. This tube makes it possible to, for example, deliver fluids, obtain blood or measure blood pressure. The tube can be inserted with or without ultrasound guidance. Ultrasound guidance allows the provider to visualise the structures beneath the skin (such as blood vessels, nerves and muscles), which makes it easier to insert the tube accurately without damaging surrounding areas. In modern practice, the use of ultrasound guidance is considered best practice, and it is therefore an integral component of the cannulation / catheterisation service and should not attract separate MBS benefits. However, a blanket requirement for ultrasound guidance is not appropriate as there are circumstances where this is not possible, appropriate or necessary. For example, it may not be necessary for experienced providers, particularly those who were trained before ultrasound was introduced as part of the standard of care.

  This recommendation supports the safe and effective delivery of health services and ensures value for patients and the community.

- Introduce MBS items for the discussion and documentation of goals of care by an Emergency Physician or Intensive Care Specialist for patients who are potentially nearing the end of their lives, where alternatives to active management may be an appropriate clinical choice, and where relevant goals of care do not already exist.

  Defining goals of care is a service that involves a comprehensive evaluation of the patient's issues (including medical, psychological, social and other issues), proactive offering of treatment alternatives (including alternatives to intensive or escalated care), and discussion of these alternatives with the patient (or surrogate decision-maker) and the patient's family, carers and other health practitioners (where appropriate).

  This recommendation focuses on improving the quality of decision-making (thereby improving patient experience), as well as enhancing value for the patient and the community. The Committee noted consumer feedback that end-of-life decisions are often made without providing sufficient information to patients and their families about the alternatives available to them. At times, this can mean that patients do not realise they have alternatives, resulting in prolonged and futile treatment that patients may not want. The Committee noted that in ideal circumstances, goals of care are defined with a provider who is familiar with the patient, prior to admission to hospital or an ICU. However, if this has not occurred, it is important to support informed choices before embarking on intensive and potentially prolonged treatment.

- Consider an expedited MSAC assessment for listing an MBS item for rapid response system / code blue attendances.

  'Code blue' calls are requests for immediate medical professional attendance for medical emergencies such as cardiac arrest. Rapid response systems—such as the Medical Emergency Team (MET) call system—are designed to request immediate medical professional attendance to manage deteriorating patients. The aim is to provide earlier clinical intervention in order to stabilise the patient and prevent further deterioration that could lead to ICU admission or result in cardiac arrest.

The proposed item is for attendances outside of EDs or ICUs by the medical practitioner taking overall responsibility for the patient in the course of the call or code response. It is not claimable in conjunction with ED attendance or ICU daily management items by the same provider.

This recommendation focuses on supporting access to this best-practice health service in order to improve patient health outcomes.

The Committee made one recommendation that aims to ensure that only safe and effective services are listed on the MBS:

- Remove obsolete item 14200 (relating to the practice of gastric lavage in the treatment of ingested poison) from the MBS.

The Committee made three recommendations that aim to ensure that the items patients are billed for more accurately reflect the services provided, and to clarify and simplify the item descriptors:

- Restructure ED attendance items into three tiered base items with add-on items.

  The three base items reflect the differing levels of professional involvement required in ED attendances, including the time required and the complexity of the service (based on the number of differential diagnoses and comorbidities that require consideration). The add-on items reflect the significant additional professional involvement required to address additional issues or perform additional tasks (such as the management of a fracture, or the need to define goals of care for a patient potentially nearing the end of his or her life). These new items replace existing MBS items.

  This recommendation focuses on ensuring that ED attendance items accurately reflect the key patient complexity factors that determine the amount of provider skill, time and risk involved. It does so by making the item descriptors clearer, which provides patients with greater billing transparency, reduces variability in item use for similar services and supports ease of auditing.

- Use a consistent item framework for all emergency attendances, regardless of the provider type. Item descriptions for professional attendances in accredited private EDs should specify the provider type and applicable schedule fee but should otherwise be the same.

  - A lower MBS benefit should apply if the provider is not an Emergency Medicine. This ‘scaled access’ to emergency attendance items should provide a fixed proportion of the benefit available for services provided by Emergency Medicine Specialists.

  This recommendation focuses on improving billing transparency for patients and providers, by ensuring the item billed reflects the nature of the service provided.

- Consider an expedited MSAC assessment for listing MBS items for extracorporeal life support, and revise items 13851 and 13854 to clarify that they are intended to cover ventricular assist devices (VADs).

  This recommendation focuses on addressing the currently ambiguous item descriptors for items 13851 and 13854, and on supporting access to best-practice health services.

The Committee made one recommendation that aims to ensure that services funded by the MBS represent good value for the patient and the community:

- Remove the differential fees for the first day (item 13847) and subsequent days (item 13848) of managing counterpulsation by intraaortic balloon.

  This recommendation simplifies the MBS and enhances value for the patient and the health system, recognising that there is no significant difference in the professional involvement required between first and subsequent days.

Recommendations fall into two categories, each of which has different next steps.

- **Recommendations to the Taskforce**. These will be considered by the Taskforce, along with feedback received during public consultation. The Taskforce will decide if these should be endorsed and recommended to the Government. The Government will then decide which recommendations to implement, and the Department of Health and other relevant agencies will work to implement them. This process may take some time.
- **Recommendations to other Clinical Committees.** These are areas where the Committee has made recommendations that are within the scope of another Clinical Committee. The relevant Clinical Committee will consider this advice and make a recommendation to the Taskforce. The Taskforce will be aware of the views of both committees when deciding what recommendation to make to the Government. These recommendations may take longer to implement as the timeline depends on the timing of other Clinical Committees.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

What is Medicare?

Medicare is Australia's universal health scheme which 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); and
- Subsidised health professional services listed on the MBS.

What is the MBS?

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

2.2 The MBS Review Taskforce

What is the MBS Review Taskforce?

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

What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on each of these four 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 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, where 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 maintain 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 will go a long way towards 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 benefits but are underused, particularly for patients who cannot readily access these services.

2.3 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 to be 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 all committees in the second tranche of the review process 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.

[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.

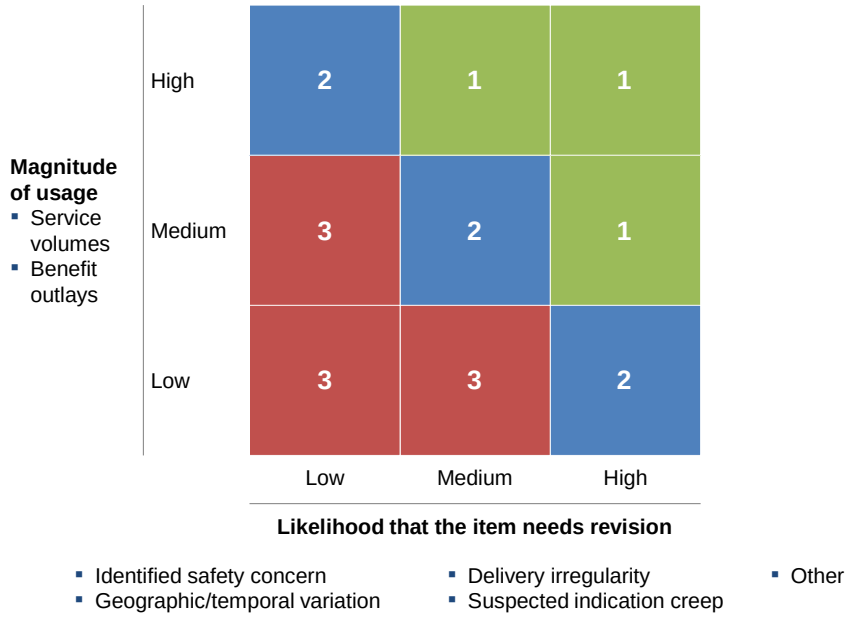
[2] The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.

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 had to develop a work plan and assign priorities, keeping in mind the objectives of the review. Committees used 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 (1):

- 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).

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 2). Clinical Committees used this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

Figure 2: Prioritisation matrix



3. About the Intensive Care and Emergency Medicine Clinical Committee

The Intensive Care and Emergency Medicine Clinical Committee (the Committee) is part of the second tranche of Clinical Committees. It was established in June 2016 to make recommendations to the Taskforce on MBS items within its remit, based on clinical expertise and rapid evidence review. The Taskforce asked the Committee to review MBS items related to emergency medicine and intensive care.

The Committee consists of 14 members and an ex-officio representative from the Taskforce. Members' names, positions/organisations and declared conflicts of interest are listed in Section 3.1. All members of the Taskforce, Clinical Committees and Working Groups were asked to declare any conflicts of interest at the start of their involvement and are reminded to update their declarations periodically.

3.1 Committee members

Table 1. Intensive Care and Emergency Medicine Clinical Committee members

Name	Position/Organisation	Declared interests
A/Prof Sally McCarthy (Chair)	Senior Emergency Physician, Prince of Wales Hospital Medical Director, Emergency Care Institute NSW Clinical Lead, NSW Whole of Hospital Program NSW Health Former President, Australasian College for Emergency Medicine	None
Dr Andrew Holt	Deputy Director & Supervisor of Training, Department of Critical Care Medicine, Flinders Medical Centre Director, Critical Care Unit, Flinders Private Hospital Director, Intensive Care Unit, Ashford Hospital Director, South Australian Home Parenteral Nutrition Unit Senior Lecturer, School of Medicine, Flinders University Chairman, Medical Advisory Committee, Adelaide Community Healthcare Alliance	None
A/Prof Andrew Turner	Director, Department of Critical Care Medicine, Royal Hobart Hospital	None
Dr David Ward	Emergency Physician, Brisbane Northside Emergency Centre (Holy Spirit Northside) Deputy Chair, Accreditation Committee, Australasian College for Emergency Medicine	None
Ms Eileen Jerga AM	Consumer Representative	None
Dr Greg McDonald	Director, Emergency Care, Sydney Adventist Hospital Member, Private Practice Committee, Australasian College for Emergency Medicine	None
A/Prof Jane Tolman	Associate Professor of Aged Care, University of Tasmania	None

Name	Position/Organisation	Declared interests
Dr Matthew Anstey	Intensive Care Specialist and Director of ICU Research, Sir Charles Gairdner Hospital Medical Advisor, Australian Commission on Safety and Quality in Health Care Board Member, Choosing Wisely Australia	None
Dr Michael Ben-Meir	Director, Emergency Department, Cabrini Health Chair, Private Practice Committee, Australasian College for Emergency Medicine	None
Prof Michael Parr	Intensive Care Unit, Liverpool Hospital, University of New South Wales	None
A/Prof Reza Ali	Director, Emergency Medicine Blacktown and Mount Druitt Emergency Department	None
Dr Simon Towler	Clinical Co-Lead, Fiona Stanley Hospital, Medical Co-Director, WA Department of Health	None
Prof Stephen Bernard	Director of Intensive Care, Knox Private Hospital Chair, Medical Advisory Committee, Knox Private Hospital Honorary Senior Intensive Care Physician, The Alfred Adjunct Professor, Monash University Department of Epidemiology and Preventive Medicine Senior Medical Advisor, Ambulance Victoria	None
Dr Yusuf Nagree	Emergency Physician, Fiona Stanley Hospital Chair, Scientific Committee, Australasian College for Emergency Medicine	None
Dr Michael Coglin (Ex-Officio)	MBS Review Taskforce Chief Medical Officer, Healthscope	None

It is noted that the majority of 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.

3.2 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 declaration periodically.

3.3 Summary of the Committee's review approach

The Committee completed a review of its items across four full Committee meetings and seven Working Group meetings, during which it developed the recommendations and rationales outlined in Sections 4–6. 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 published literature, all of which is referenced in the report.

3.3.1 Working Group structure

The Committee reviewed 29 items and made recommendations based on the best available evidence and clinical expertise, in consultation with relevant stakeholders. The Committee formed three Working Groups with broader membership to provide greater content expertise on specific domains of clinical practice:

- The Emergency Medicine Working Group (EDWG).
- The Intensive Care Working Group (ICUWG).
- The End-of-Life Care Working Group (EoLWG).

The Committee's major recommendation involves restructuring Emergency Department (ED) attendance items into three tiered base items with add-on items.

Minor recommendations include the removal of an obsolete item (for gastric lavage); removal of unnecessary distinctions between items (between first and subsequent days of management of counterpulsation by intraaortic balloon); clarifying items to encourage best practice (use of ultrasound with vascular catheterisation); clarifying items to distinguish between different services (circulatory support using ventricular assist devices [VAD] or extracorporeal life support); and adding items to support access to best-practice health services (professional attendances for rapid response system / code blue referrals, and services relating to defining the goals of care for potentially end-of-life patients before deciding to admit them to hospital or intensive care).

The Committee also recommended leaving a number of items unchanged (including the daily management items for intensive care and the invasive pressure monitoring item).

All recommendations focus on the objectives of the MBS Review: improve access to medical services, encourage best practice, increase value for consumers and the health system, and simplify the MBS to improve both patient and provider experience (for example, through improved transparency around services billed), as well as the efficiency with which the MBS is administered.

An inclusive set of stakeholders is now engaged in consultation on the recommendations resulting from this process, which are outlined in this report. Following this period of consultation, the Committee will consider stakeholder feedback before finalising the recommendations and presenting them to the Taskforce. The Taskforce will consider the report and stakeholder feedback before making recommendations to the Minister for Health for consideration by the Government.

3.3.2 Structure of the report

The recommendations in this report are organised by the primary deliberating body that developed the recommendations, with the exception of the recommendation regarding goals of care (discussion, decision-making and documentation). This recommendation was developed primarily by the EoLWG but has been integrated into the relevant emergency medicine and intensive care sections of this report.

- Section 4 – Emergency medicine recommendations on issues relating to:
  - Emergency Department attendance items.
  - Consistent item structure for all Emergency Department attendances.
  - MBS item use for Short Stay Units.
- Section 5 – Intensive care recommendations on issues relating to:

- Intensive care daily management items (13870 and 13873) and the invasive pressure monitoring item (13876).
- Management of counterpulsation by intraaortic balloon (items 13847 and 13848).
- Circulatory support items (13851 and 13854) and coverage of ventricular assist devices and extracorporeal life support.
- Vascular catheterisation items (13815 and 13842) and use of ultrasound.
- An item for goals-of-care services provided by Intensive Care Physicians.

Δ Section 6 – General recommendations on issues relating to:

- Gastric lavage item (14200).
- An MBS item for rapid response system / code blue attendance services.
- Items for which no concerns were raised.
- Remuneration of Emergency Physicians.

3.3.3 Numbering of proposed items

Throughout the report, the Committee recommends new or substantially changed items, most of which involve restructuring current items. These proposed items are often referred to using letters to differentiate them for ease of reference. If the recommended items are ultimately added to the MBS, the Department of Human Services (DHS) will assign new numbers in the usual format. The Committee is not recommending changes to the MBS numbering system.

4. Emergency medicine recommendations and requests

4.1 Emergency Medicine Working Group membership

The Committee formed a Working Group to consider emergency medicine services. The Emergency Medicine Working Group (EDWG) included the members listed in Table 2.

Table 2. Emergency Medicine Working Group members

Name	Position/Organisation	Interests declared
Dr Michael Ben-Meir* (Chair)	Director, Emergency Department, Cabrini Health Chair, Private Practice Committee, Australasian College for Emergency Medicine	None
Dr David Rosengren	Director & Emergency Physician, Emergency Centre, Greenslopes Private Hospital Senior Lecturer, School of Medicine, The University of Queensland Chair, Queensland Clinical Senate	None
Dr David Ward*	Emergency Physician, Brisbane Northside Emergency Centre (Holy Spirit Northside) Deputy Chair, Accreditation Committee, Australasian College for Emergency Medicine	None
Ms Eileen Jerga AM *	Consumer Representative	None
Dr Greg McDonald*	Director, Emergency Care, Sydney Adventist Hospital Member, Private Practice Committee, Australasian College for Emergency Medicine	None
Dr Matthew Anstey*	Intensive Care Specialist and Director of ICU Research, Sir Charles Gairdner Hospital Medical Advisor, Australian Commission on Safety and Quality in Health Care Board Member, Choosing Wisely Australia	None
Dr Paul Bailey	Director of Emergency Medicine, St John of God Hospital Murdoch	None
A/Prof Reza Ali*	Director, Emergency Medicine Blacktown and Mount Druitt Emergency Department	None
Dr Yusuf Nagree*	Emergency Physician, Fiona Stanley Hospital Chair, Scientific Committee, Australasian College for Emergency Medicine	None
A/Prof Sally McCarthy (Committee Chair)*	Senior Emergency Physician, Prince of Wales Hospital Medical Director, Emergency Care Institute NSW Clinical Lead, NSW Whole of Hospital Program NSW Health Former President, Australasian College for Emergency Medicine	None

*Also a member of the Committee.

It is noted that the majority of 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.

The EDWG developed the following recommendations. Recommendation 2 has been amended by the Taskforce for consistency across the MBS Review. All recommendations have otherwise been endorsed unanimously by the Committee.

4.2 Emergency Department attendance items (501–536)

The MBS currently has 11 items related to ED attendances, of which five (501–515) relate to attendances tiered into five levels of complexity (Levels 1 to 5). The remaining six items (519–536) relate to prolonged attendances for critically ill patients with immediately life-threatening problems (requiring resuscitation). These items are tiered by time into six categories: up to one hour, two hours, three hours, four hours or five hours, and five hours or more).

These 11 items relate only to services provided at a recognised ED of a private hospital by a medical practitioner who is an Emergency Physician. Emergency Physicians are medical practitioners who are Fellows of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the Australasian College for Emergency Medicine (ACEM).

Table 3: Item introduction table for items 501–536

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
501	Level 1 Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine. Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focused history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making.	$34.20	1,791	$55,379	8.0%
503	Level 2 Professional attendance on a patient at a recognised Emergency	$57.80	12,680	$712,539	-8.2%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	Department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine. Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focused history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity.				
507	Level 3 Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine. Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focused history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity.	$97.05	27,329	$2,576,136	0.9%
511	Level 4 Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an	$137.30	28,370	$3,806,402	7.4%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	emergency medicine physician in the practice of emergency medicine. Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity.				
515	Level 5 Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine. Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity.	$212.60	19,395	$3,909,046	21.5%
519	Professional attendance on a patient at a recognised Emergency	$146.20	71	$9,586	-3.1%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	Department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine. Attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed… …for a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient.				
520	… for a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient.	$280.85	470	$125,551	14.5%
530	… for a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient.	$460.30	235	$99,299	11.4%
532	… for a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient.	$639.75	68	$39,545	1.2%
534	… for a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient.	$819.35	17	$14,298	-15.3%
536	… for a period of 5 hours or more of total physician time spent with each patient.	$909.10	19	$16,193	-9.3%

Recommendation 1

- Restructure ED attendance items into three tiered base items with add-ons items.
  - The three tiered base items reflect the differing levels of professional involvement required during emergency attendances, based on the number of differential diagnoses and comorbidities that require consideration.
  - The add-on items are designed to reflect the significant additional professional involvement associated with issues or tasks that may be performed in an ED context, but that are not a standard component of any particular base item. Specifically, these items cover resuscitation (for half an hour to one hour, one to two hours, or two hours or more), anaesthesia, minor procedures, procedures, fracture / dislocation management excluding aftercare, fracture / dislocation management including aftercare, care for patients above the age of 75 or below the age of two, chemical or physical restraints, and goals of care.
  - Other MBS items should not be used for services (or components of services) provided in the course of an ED attendance (i.e., services rendered by an Emergency Physician in conjunction with an ED attendance). Add-on items should be used instead of all existing MBS procedural items, such as anaesthetics items.

  The proposed item descriptors and explanatory notes are provided below.

Item 50X:

STANDARD EMERGENCY ATTENDANCE

Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an Emergency Physician in the practice of Emergency Medicine, for the consultation, investigation (if required) and management of a single system issue in a patient with no relevant comorbidities where the differential diagnosis is limited.

Includes targeted history and examination, routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block), interpretation of relevant investigations (if required), development and initiation of a management plan, relevant GP and specialist communication and associated documentation. These patients would typically be discharged home from the Emergency Department.

Item 50Y:

ADVANCED EMERGENCY ATTENDANCE

Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an Emergency Physician in the practice of Emergency Medicine, for the assessment, investigation and management of an undifferentiated presentation or a presentation with a clear diagnosis that needs risk stratification and complication exclusion. Where the diagnosis is clear from the outset this item should be used when management is time consuming or more than one strategy is required. May include referral or consultation with alternate specialist(s). These patients may or may not be admitted.

Includes a period of observation in response to initial treatment and / or requiring results of investigations to inform an ongoing management plan, and includes any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

Item 50Z:

COMPLEX EMERGENCY ATTENDANCE

Professional attendance on a patient at a recognised Emergency Department of a private hospital by a medical practitioner who is an Emergency Physician in the practice of Emergency Medicine, for the assessment, investigation and management of an undifferentiated ED patient with one or more comorbidities and more than one differential diagnosis.

This item may include time consulting with alternate specialists, liaising with community services and arrangement of admission, pharmacy reconciliation, communication with family, carers and general practitioners; and any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

Item 51A:

RESUSCITATION, 0.5 – 1 HRS

Resuscitation of a critically ill patient with an immediately life threatening problem requiring immediate attendance by an Emergency Physician, for a period of not less than 30 minutes but less than 1 hour of total physician time.

Including all common procedures and processes involved in a resuscitation, such as rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with focused assessment with sonography for trauma (FAST scan), central line access, arterial puncture and or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion.

Item to be used only in conjunction with Items 50X–50Z.

Item 51B:

RESUSCITATION, 1 – 2 HRS

Resuscitation of a critically ill patient with an immediately life threatening problem requiring immediate attendance by an Emergency Physician, for a period of not less than 1 hour, but less than 2 hours of total physician time.

Including all common procedures and processes involved in a resuscitation, such as rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with focused assessment with sonography for trauma (FAST scan), central line access, arterial puncture and or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion.

Item to be used only in conjunction with Items 50X–50Z.

Item 51C:

RESUSCITATION, 2+ HRS

Resuscitation of a critically ill patient with an immediately life threatening problem requiring immediate attendance by an Emergency Physician, for a period of 2 or more hours of total physician time.

Including all common procedures and processes involved in a resuscitation, such as rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with focused assessment with sonography for trauma (FAST scan), central line access, arterial puncture and or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion.

Item to be used only in conjunction with Items 50X–50Z.

Item 51D:

ANAESTHESIA OR EMERGENT INTUBATION

IV sedation, regional anaesthesia or emergent intubation by a second Emergency Physician.

In the case of sedation or regional anaesthesia, including pre-anaesthetic consultation and the associated procedure (e.g., direct current cardioversion or hip enlocation).

In the case of emergent intubation, including all common procedures and processes involved in intubation, such as rapid sequence induction, insertion of an endotracheal tube under direct visualisation and / or video laryngoscopy (or alternative airway access procedures such as awake nasal intubation, or the creation of a surgical airway).

Item to be used only for a patient receiving services under items 50X–50Z from a first Emergency Physician. The second Emergency Physician providing this service may not claim any other items in the management of the patient (including any other anaesthesia related items on the Medicare Benefits Schedule).

Item 51E:

MINOR PROCEDURE

Minor procedure performed by an Emergency Physician. Item to be used only in conjunction with Items 50X–50Z, and may be claimed for each minor procedure performed.

Item 51F:

PROCEDURE

Procedure performed by an Emergency Physician. Item to be used only in conjunction with Items 50X–50Z, and may be claimed for each procedure performed.

Item 51G:

FRACTURE / DISLOCATION EXCLUDING AFTERCARE

Fracture or dislocation diagnosis and management by an Emergency Physician, excluding aftercare. Includes all fractures and dislocations diagnosed and managed.

Item to be used only in conjunction with Items 50X–50Z.

Item 51H:

FRACTURE / DISLOCATION INCLUDING AFTERCARE

Fracture or dislocation diagnosis and management by an Emergency Physician, including aftercare. Includes all fractures and dislocations diagnosed and managed.

Item to be used only in conjunction with Items 50X–50Z.

Item 51I:

PATIENT ABOVE 75 OR BELOW 2 YEARS OF AGE

A patient receiving services as described in item 50X, 50Y or 50Z, who is above 75 years or below 2 years of age.

Item to be used only in conjunction with Items 50X–50Z.

Item 51J:

CHEMICAL OR PHYSICAL RESTRAINTS

A patient receiving services as described in item 50X, 50Y or 50Z, where an acute severe behavioural disturbance necessitates involuntary management with a team based approach and chemical and / or physical restraints (limited) and / or one on one nursing care to ensure the safety of the patient.

Item 51K:

GOALS OF CARE IN CONJUNCTION WITH ED ATTENDANCE

Professional attendance by an Emergency Physician for the discussion and documentation of goals of care:

(a) For a patient

i. Experiencing either a life-threatening acute illness, or an acute illness in the context of a high baseline risk for end-of-life within the next 12 months, and

ii. For whom alternatives to active management are reasonably thought to be an appropriate clinical choice, and

iii. For whom an appropriate documentation of goals of care does not already exist or these goals are reasonably expected to change substantially due to new clinical circumstances;

(b) Including

i. Assessment of the patient's capacity to make goals of care decisions, and

ii. Comprehensive evaluation of the patient's medical, physical, psychological and social issues, including identification of major issues requiring goals of care to be defined, and

iii. Discussion with the patient (or surrogate), which must include proactive offering of treatment alternatives, including alternatives to intensive or escalated care; and, where appropriate, with the patient's family, carers and other health practitioners, and

iv. Agreement on the goals of care, between the provider and the patient or their guardian, and in relation to all major medical issues identified in the comprehensive assessment, and

v. Documentation of the goals of care in a way that facilitates timely retrieval by subsequent healthcare providers for the patient, and includes what interventions should and should not be pursued;

(c) Claimable

i. Once only per episode of care,

ii. For the medical practitioner taking overall responsibility for the agreement and documentation of goals of care.

Item to be used only in conjunction with Items 50X–50Z.

Where this service is rendered by a provider who is familiar with the patient's medical issues and circumstances (i.e., is rendered in conjunction with ED attendance items 50X–50Z), Item 51K should be used. Where this service is rendered by an Emergency Physician who is otherwise unfamiliar with

the patient (i.e., where a prior ED attendance service has not been rendered by the provider), Item 51L should be used.

Item 51L:

GOALS OF CARE NOT IN CONJUNCTION WITH ED ATTENDANCE

Professional attendance by an Emergency Physician for the discussion and documentation of goals of care:

(a) For a patient

i. Experiencing either a life-threatening acute illness, or an acute illness in the context of a high baseline risk for end-of-life within the next 12 months, and

ii. For whom alternatives to active management are reasonably thought to be an appropriate clinical choice, and

iii. For whom an appropriate documentation of goals of care does not already exist or these goals are reasonably expected to change substantially due to new clinical circumstances;

(b) Including

i. Assessment of the patient's capacity to make goals of care decisions, and

ii. Comprehensive evaluation of the patient's medical, physical, psychological and social issues, including identification of major issues requiring goals of care to be defined, and

iii. Discussion with the patient (or surrogate), which must include proactive offering of treatment alternatives, including alternatives to intensive or escalated care; and, where appropriate, with the patient's family, carers and other health practitioners, and

iv. Agreement on the goals of care, between the provider and the patient or their guardian, and in relation to all major medical issues identified in the comprehensive assessment, and

v. Documentation of the goals of care in a way that facilitates timely retrieval by subsequent healthcare providers for the patient, and includes what interventions should and should not be pursued, with

vi. At least 60 minutes of dedicated professional involvement;

(c) Claimable

i. Once only per episode of care,

ii. For the medical practitioner taking overall responsibility for the agreement and documentation of goals of care.

This item is not payable for the same patient on the same day as Items 50X–50Z.

Where this service is rendered by a provider who is familiar with the patient's medical issues and circumstances (i.e., is rendered in conjunction with ED attendance items 50X–50Z), Item 51K should be used. Where this service is rendered by an Emergency Physician who is otherwise unfamiliar with the patient (i.e., where a prior ED attendance service has not been rendered by the provider), Item 51L should be used.

Explanatory notes for items 50X–50Z:

Items 50X to 50Z relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate

in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

Other than for point-of-care ultrasound (see below), only modifying items 51A–51L may be claimed in conjunction with items 50X–Z.

Items relating to point-of-care ultrasound services are not separately payable from Emergency Department attendance items 50X–Z where performed for a reason that represents routine use as standard of care in an Emergency Department attendance. For example, the following four (non-exhaustive) reasons:

(a) To identify nerves for the purposes of administering nerve blocks.

(b) To identify vessels, including abdominal aortic aneurysms.

(c) As part of a focused assessment with sonography for trauma (FAST) scan.

Where the "standard of care" principle does not apply, items relating to point-of-care ultrasound services are payable in addition to Emergency Department attendance items 50X–Z, where the following three criteria are met:

(a) A formal report is provided and is stored in a manner that reasonably facilities future retrieval / access.

(b) The images are stored in a manner that reasonably facilitates future retrieval / access.

(c) The provider is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of ultrasound services.

For the sake of clarity, hospitals do not constitute recognised bodies for the credentialing of ultrasound services. The Australasian College for Emergency Medicine (ACEM) has published policy on the appropriate credentialing for Emergency Medicine ultrasonography, such as the "Policy on Credentialing for Emergency Medicine Ultrasonography: Trauma Examination & Suspected AAA." As noted by ACEM, examples of appropriate credentials include the Diploma in Diagnostic Ultrasound (DDU) and the Certificate in Clinician Performed Ultrasound (CCPU) offered by the Australasian Society for Ultrasound in Medicine (ASUM).

Explanatory notes for items 51A–51C:

Patients requiring resuscitation often require a second Emergency Physician to assist with access, airway or other procedures as required. Only one Emergency Physician (the Emergency Physician holding primary responsibility for the patient) may bill the Emergency Department attendance item (50X–50Z). The second Emergency Physician may bill a time-based resuscitation add-on (items 51A–51C) and an emergent intubation add-on (item 51D).

Explanatory notes for item 51D:

This item accounts for all services that would otherwise be billed under the anaesthetic items in the Medicare Benefits Schedule, including the pre anaesthetic consultation, the associated procedure, and any loadings / add-ons (such as duration of anaesthesia or the ASA classification of the patient). Anaesthesia under Item 51D assumes an average of 20 minutes anaesthesia, and an average ASA 3 classification, in an emergent and / or after-hours context.

Patients requiring resuscitation or procedural sedation often require a second Emergency Physician to assist with access, airway or other procedures as required. Only one Emergency Physician (the Emergency Physician holding primary responsibility for the patient) may bill the Emergency Department attendance item (50X–50Z). The second Emergency Physician may bill a time-based resuscitation add-on (items 51A–51C) and an emergent intubation add-on (item 51D).

Explanatory notes for item 51E:

Minor procedures could include foreign body removal (including from the eye or nose), burns dressing & consult, incision and drainage abscess / cyst / haematoma (including Bartholin's), pulp space drainage, removal of nail of finger, thumb or toe, incision of thrombosed external haemorrhoid, superficial <7 cm laceration repair not of the face or neck, abdominal paracentesis, thoracic cavity aspiration for diagnostic purposes (without therapeutic drain), bladder aspiration (suprapubic tap), passage of urethral sounds, paraphimosis reduction, sigmoidoscopy, skin biopsy, removal of etonogestral subcutaneous implant, venesection.

Explanatory notes for item 51F:

Procedures could include lumbar puncture, thoracic cavity aspiration with therapeutic drainage, removal of foreign body from the ear or subcutaneous tissue (incision / closure), excision of skin lesions / cysts, sinus excision, superficial laceration repair of the face / neck (including ear, eyelid, lip, nose) or of >7cm, management of deep, contaminated wound requiring debridement under general anaesthetic or field block, femoral nerve block, epistaxis cautery / packing, suprapubic cystotomy / catheter, cardioversion / defibrillation, intercostal drain insertion, PEG tube replacement, laryngoscopy (including fibreoptic), priapism decompression.

Explanatory notes for items 51K and 51L:

a) *Patients could be assessed for "high baseline risk" (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the SPICT tool.*

b) *"Proactive offering of treatment alternatives" means that the patient must be provided with reasonable alternatives to continued intensive / active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).*

c) *"Documentation" should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.*

d) *Providers of this service should be appropriately trained to provide end-of-life care options and goals of care discussions.*

e) *The item should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.*

Rationale

This recommendation focuses on ensuring that ED attendance items accurately reflect the key patient complexity factors that determine the amount of provider skill, time and risk involved. It aims to do so by making the item descriptors clearer, which will provide patients with greater billing transparency, reduce variability in item use for similar services and support ease of auditing.

- Δ The existing ED attendance items (501–515) warrant revision due to the ambiguity in the item descriptors, which creates a risk of misinterpretation. This is likely to result in inconsistency and variation between providers regarding what item (complexity level) is billed for similar services. The MBS benefit a patient receives may therefore depend on the billing practices of the provider, rather than the nature of the service rendered. The 'resuscitation' items (519–536) also do not accurately reflect attendance complexity.
  - In practice, three of the five complexity levels are typically used, with the vast majority of services categorised as Levels 3-5 (Figure 3). The Level 1 (lowest complexity) ED attendance item (501) is rarely used, and use of the Level 2 item (503) is decreasing. However, growth in service volumes for the Level 5 item (highest complexity) is nearly three times larger than

the growth for any other level. The 'resuscitation' items (519–536) are rarely used, with small and fluctuating service volumes of less than 1,000 instances per year (Figure 4).

- A submission from the Australasian College for Emergency Medicine (ACEM) noted that these items "are both confusing and open to variation in interpretation" and "do not reflect current ED practices … [Duration and qualitative complexity level] fail to capture the complexity involved."

Δ The Committee felt that creating three tiers represents the optimal balance of adequately differentiating levels of patient complexity while maintaining a manageable number of levels to support accurate allocation of complexity levels (i.e., MBS items) to services rendered.

- Including only one tier carries a substantial risk of providers "cherry-picking" low-complexity patients and would not adequately reflect case-mix variation between departments. For example, private EDs may differ in terms of the proportion of paediatric and geriatric cases, the admission rate and the clinical conditions seen (which may vary based on the specialist services available in the hospital to which the ED is attached).
- Including only two tiers would not allow enough specificity to adequately differentiate between levels of patient complexity.
- Including four or more tiers would create opportunities for misinterpretation, increasing the risk of miscategorising the complexity level of ED attendances (i.e., the risk of miscoding or upcoding).

Δ The word "standard" is preferable to the word "simple" for items covering ED attendances. Attendances where diagnosis and management are clear (for example, for otitis media, a simple rash or simple injuries such as small lacerations or wounds) are uncommon, representing only 7 per cent of ED attendances, and Emergency Physicians are unlikely to view a consultation as straightforward. An item for a "simple" ED attendance is therefore unlikely to be used.

Δ Some procedural services form part of the standard of care received in an emergency attendance and should be considered an integral component of the attendance item. Billing these services separately adds to the administrative burden and creates a potential incentive to over-service, and it should not occur.

- These procedures include electrocardiograms (ECGs), in-dwelling urinary catheterisation, venous and arterial blood gas sampling, and point-of-care ultrasound for reasons including (but not limited to) the following:
  - Identifying nerves for the purposes of administering nerve blocks.
  - Identifying vessels, including abdominal aortic aneurysms.
  - Undertaking a focused assessment with sonography for trauma (FAST) scan.

Δ In the case of resuscitation add-on items 51A-C, procedural services that form part of the standard of care involved in a resuscitation include rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with a FAST scan, central line access, arterial puncture and/or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion. These should be considered integral components of the items.

Δ Add-on items cover the major sources of increased professional involvement. The Committee felt that use of these add-on items (instead of other MBS items) would reduce the number of items that need to be billed for each patient and for each provider. This would reduce variation in the item combinations used by providers, which, in turn, would reduce variation in the

Medicare benefits patients receive for similar services. It would also ease the administrative burden associated with using more than 100 items across the MBS.

- When providing safe and effective resuscitation of the critically unwell patient, anaesthesia and / or intubation, best practice requires the professional involvement of two medical practitioners.
- Fractures and dislocations were separated from other procedural add-ons to support billing transparency for patients receiving these common procedures. This also allows aftercare requirements to be better articulated.
- The Committee noted that patients who are very young or elderly require a greater amount of professional involvement than is reflected in the complexity-tiered base items.
    - Age is one determinant of the level of professional involvement required and is not simply a proxy for other factors (such as the number of differential diagnoses or comorbidities, or the period of observation time required). This is because differing physiological requirements affect drug dosing, there can be difficulties associated with communication and co-operation, and there is greater complexity in pain and distress management.
    - Although the recommendation to reduce the number of tiers from five to three improves ease of comprehension and use (and therefore the consistency and accuracy of billing), it affords less discrimination between differing levels of complexity. However, age is a more objective measure of complexity than additional complexity tiers for base items, and it can be automatically verified during claims processing.
- Defining goals of care is an important service that is separate from the ED attendance and results in better quality and value for patients. However, the Committee noted the following:
    - Efforts to define patients' goals of care are inconsistent and are often undertaken at a later stage than is clinically useful. Patients attended by Emergency Physicians or Intensivists often have not had goals of care defined by their primary General Practitioner (GP).
    - The lack of early decision-making regarding goals of care may result in over-treatment and / or excessive lengths of stay. In particular, there are patients who may not wish to proceed with active treatment but may feel that they have not been given alternative options to consider.
    - Emergency Physicians often bear responsibility for initiating discussion regarding the goals of care. This requires a significant level of professional involvement, due to the acuity of the situation and the importance of clarifying goals of care prior to admission to hospital or the Intensive Care Unit (ICU). It also requires complex discussions and decision-making for a patient with whom the provider is unfamiliar.
- The level of professional involvement required in defining goals of care is greater if the patient is unfamiliar to the provider. Less professional involvement is required if the provider is familiar with the patient, having participated in the patient's emergency attendance. (In the latter situation, the provider may have previously reviewed the patient's medical records and history.) The Committee felt that separate items—with differing time requirements and schedule fees—were needed to reflect this.

Δ Schedule fees for the proposed items are expected to reflect the volumes of bundled procedural components, where benefits for these procedural components were previously separately payable under their respective items. For example, routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling,

ultrasound in conjunction with procedures such as vascular access or nerve block), which are now bundled within proposed ED attendance items 50X–Z. This will require appropriate analyses / modelling to be conducted. Further, the Committee should be provided with an opportunity to engage with the Department in the process of determining Schedule Fees for the proposed items.

Figure 3: Level 1–5 ED attendance items

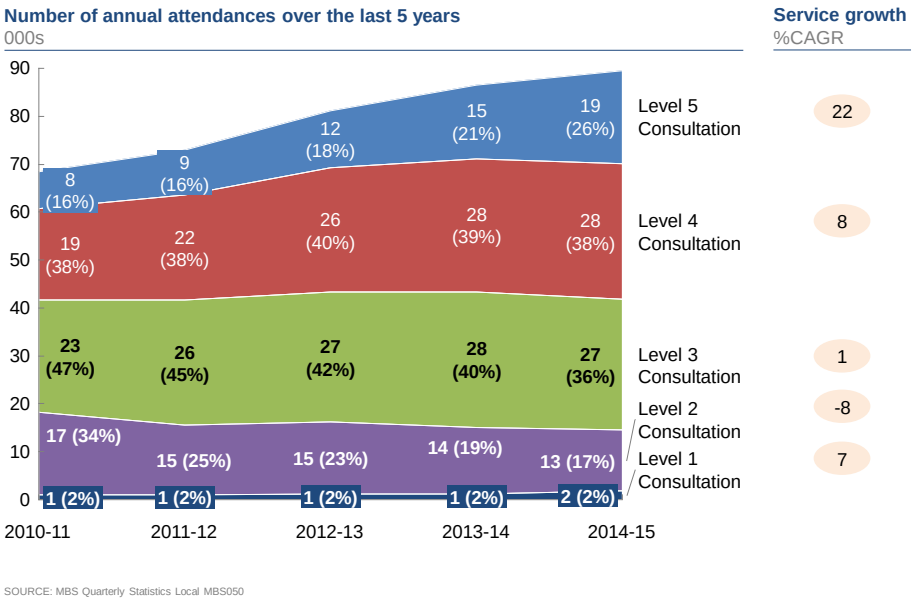
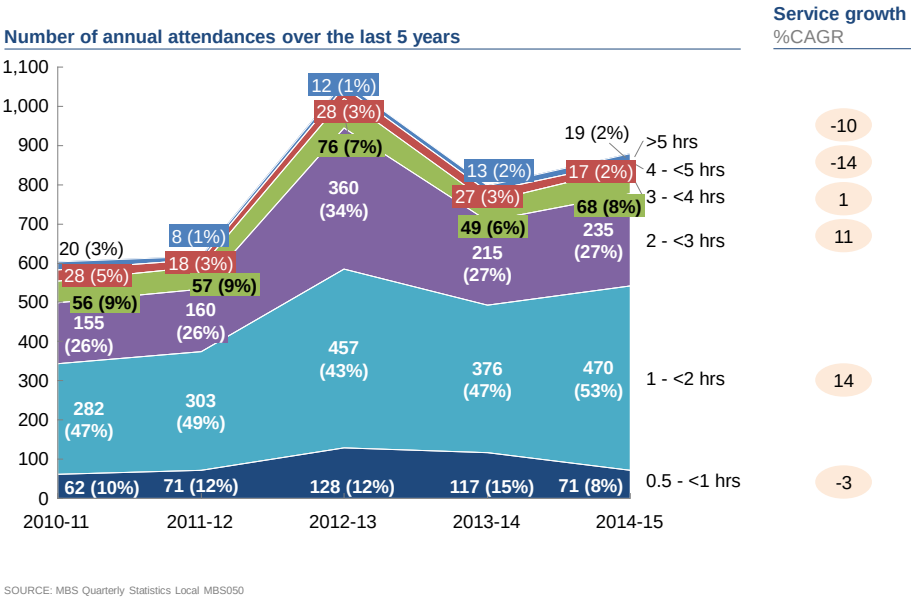


Figure 4: 'Resuscitation' ED attendance items



4.3 Consistent item structure for all Emergency Department attendances

Recommendation 2

- Use a consistent item framework for all emergency attendances, regardless of the provider type.
  - Item descriptions for professional attendances in accredited private EDs should specify the provider type and applicable schedule fee but should otherwise be the same, regardless of whether the item is provided by a specialist Emergency Physician, a trainee in emergency medicine, a GP (whether vocationally registered or non-vocationally registered), or another medical practitioner.
  - A lower MBS benefit should apply if the provider is not a vocationally recognised Emergency Medicine Specialist (i.e., an Emergency Physician, defined by recognition as a Fellow of the ACEM). This 'scaled access' to emergency attendance items should provide a fixed proportion of the benefit available for services provided by Emergency Medicine Specialists.

  The proposed item descriptors and explanatory notes are the same as those provided in Section 4.2 – Emergency Department attendance items, except that they also specify the provider type and applicable schedule fee. Specifically, in place of "medical practitioner who is an Emergency Physician in the practice of Emergency Medicine," item descriptors should specify "medical practitioner who is not an Emergency Physician in the practice of Emergency Medicine".

Rationale

This recommendation focuses on improving billing transparency for patients and providers, by ensuring the item billed reflects the nature of the service provided. It is based on the following observations.

- MBS benefits should maintain the primacy of vocational recognition as an Emergency Medicine Specialist by the Australasian College of Emergency Medicine as the professional gold standard in training to provide safe, effective, high-value emergency medical care in Australia. Access to the higher MBS benefit should therefore be reserved for those who have attained this recognition.
- While encouraging providers other than Emergency Medicine Specialists to gain emergency attendance experience provides a valuable opportunity for these providers to up-skill, such medical practitioners provide an important but substantively different skillset, and therefore an important but substantively different level of ED attendance service. The Taskforce felt that such services should attract a lower MBS benefit than those provided by Emergency Medicine Specialists.
  - Such providers may include vocationally registered GPs (VRGPs), non-vocationally recognised GPs (non-VRGPs) and trainees in emergency medicine, among others. There are no substantive differences between emergency medicine services provided by VRGPs and non-VRGPs. Many non-VRGPs have substantial experience in providing services in the ED context.

4.4 MBS item use for Short Stay Units

Recommendation 2.1

- The Committee requests that the Consultation Services Clinical Committee consider recommendations to allow referred in-hospital attendance services provided by Emergency

Physicians to attract a patient rebate equivalent to that received for attendances by Consultant Physicians.

Rationale

This request focuses on supporting access to best-practice health services. It is based on the following observations.

- Short Stay Units (SSUs) provide care for admitted patients with a short anticipated length of stay (typically less than 24 hours) until they are discharged. These patients have usually received prior review in an ED, and they usually have a management plan that requires observation and medical practitioner attendance to review the patient's clinical condition and investigation results, and to adjust the management plan appropriately.
- Attendances for patients in SSUs may be provided by Emergency Physicians, other Inpatient Specialists or Consultant Physicians, all of whom bring unique skills to bear in the given clinical context.
  - If an SSU is located outside the accredited private ED, the ED attendance items do not apply, and Emergency Physician attendance services are instead covered by the MBS under inpatient referred specialist consultation items 104 and 105. ED attendance items may also not always appropriately describe SSU attendance services. For example, the nature of the service differs from that for the undifferentiated, acute patient first presenting to an ED, where a complete history must be taken, investigations requested and an initial management plan formulated.
  - Emergency Physicians bring particular expertise in extended service provision and rapid turnover of patients, and provide a cognitive service similar to those provided by Consultant Physicians in the SSU context. Patients should not receive lower benefits for attendances by Emergency Physicians than they would receive for similar attendances by Consultant Physicians.

5. Intensive care recommendations

5.1 Intensive Care Working Group membership

The Committee formed a Working Group to consider intensive care services. The Intensive Care Working Group (ICUWG) included the members listed in Table 4.

Table 4. Intensive Care Working Group members

Name	Position/Organisation	Interests declared
A/Prof Andrew Turner* (Chair)	Director, Department of Critical Care Medicine, Royal Hobart Hospital	None
Ms Eileen Jerga AM*	Consumer Representative	None
A/Prof George Skowronski	Senior Staff Specialist, St George Intensive Care Unit Former President, Australian and New Zealand Intensive Care Society Former Chairman, Intensive Care Specialist Advisory Committee, Royal Australasian College of Physicians	None
Dr Mark Nicholls	Senior Staff Specialist, Intensive Care, St Vincent's Hospital, Sydney Chair, Practice and Economics Committee, Australian and New Zealand Intensive Care Society	None
Dr Matthew Anstey*	Intensive Care Specialist and Director of ICU Research, Sir Charles Gairdner Hospital Medical Advisor, Australian Commission on Safety and Quality in Health Care Board Member, Choosing Wisely Australia	None
Prof Michael Parr*	Intensive Care Unit, Liverpool Hospital, University of New South Wales	None
Dr Simon Towler*	Clinical Co-Lead, Fiona Stanley Hospital, Medical Co-Director, WA Department of Health	None
Prof Stephen Bernard*	Director of Intensive Care, Knox Private Hospital Chair, Medical Advisory Committee, Knox Private Hospital Honorary Senior Intensive Care Physician, The Alfred Adjunct Professor, Monash University Department of Epidemiology and Preventive Medicine Senior Medical Advisor, Ambulance Victoria	None

Name	Position/Organisation	Interests declared
A/Prof Sally McCarthy* (Committee Chair)	Senior Emergency Physician, Prince of Wales Hospital Medical Director, Emergency Care Institute NSW Clinical Lead, NSW Whole of Hospital Program NSW Health Former President, Australasian College for Emergency Medicine	None

*Also a member of the Committee.

It is noted that the majority of 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.

The ICUWG developed the following recommendations, which were unanimously endorsed by the Committee.

5.2 Intensive care daily management items (13870 and 13873) and the invasive pressure monitoring item (13876)

Table 5: Item introduction table for items 13870, 13873 and 13876

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13870	Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care – including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation – management on the first day. (H)	$362.10	64,863	$17,616,540	8.3%
13873	Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care – including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation – management on each day subsequent to the first day.	$268.60	190,443	$38,362,962	6.2%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	(H)				
13876	Central venous pressure, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care – once only for each type of pressure on any calendar day (up to a maximum of 4 pressures). (H)	$76.90	278,678	$16,079,720	4.9%

Recommendation 3

- Leave items 13870, 13873 and 13876 unchanged.

Rationale

This recommendation is based on the following observations.

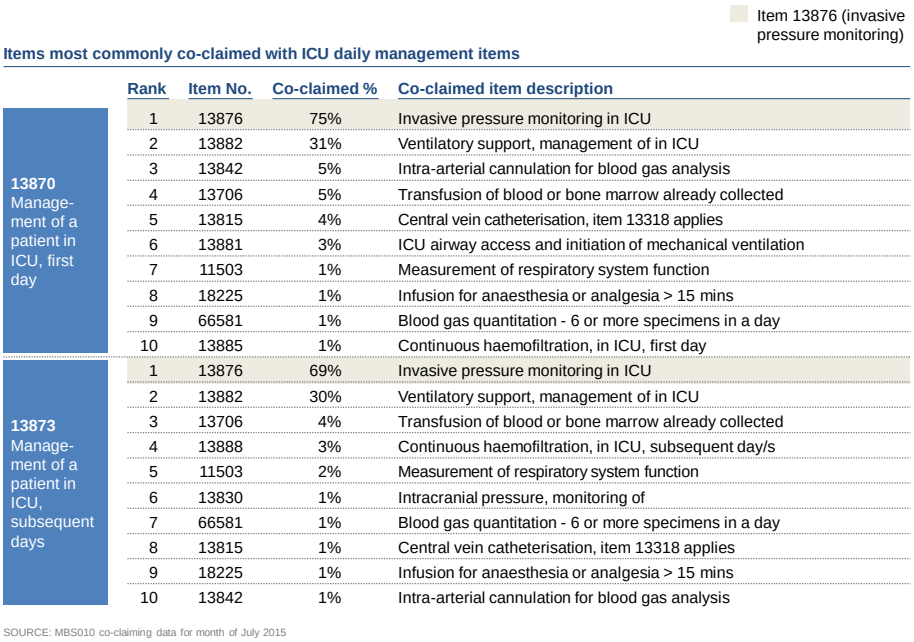
- The Committee noted that item 13876 reflects intervention on sicker patients, and therefore has always been intended to function, additionally, as a surrogate for complexity.
  - ICU daily management items 13870 and 13873 were initially developed to reflect Intensivist attendance equivalent to three Physician consults: a morning ward round, an evening ward round and one further attendance to the patient. For this reason, only procedures integral to such a consult (for example, ECG monitoring, arterial sampling and bladder catherisation) are bundled. No other provisions account for differences in professional involvement based on the complexity of the patient's clinical condition.
- The Committee felt that item 13876 reflects contemporary intensive care practice and is an accurate and scalable surrogate for complexity. As a result, it concluded that there was no compelling reason for altering the existing arrangements. The Committee agreed on the following points:
  - Hypoxia and vasopressor requirements are an appropriate surrogate for complexity in the ICU context.
  - Item 13876 can be claimed up to four times per day—depending on the number of different pressure types monitored (for example, central venous pressure or cardiac intra-cavity pressure)— and therefore functions as a scalable proxy for complexity.
  - Use of invasive pressure monitoring is both simple and auditable, reducing the chances of item misuse (such as upcoding to higher complexity items, which may occur with alternative systems that account for complexity but do not unambiguously differentiate between clinical situations).

- There is no evidence of misuse or over-servicing of item 13876.
  - Australian ICUs are intended to handle a case-mix that requires invasive monitoring. In this context, the usage rates are within the expected range (co-claimed in 75 per cent of instances where item 13870 is provided, and 70 per cent where item 13873 is provided; Figure 5).
  - Intensive Care Specialists are vigilant in removing unnecessary invasive devices as soon as possible in order to minimise the risk of complications, such as bloodstream infection. Furthermore, ICUs are required to report central line-associated blood stream infection (CLABSI) to the Australia and New Zealand Intensive Care Society's (ANZICS) Centre for Outcome and Resource Evaluation (CORE) registry in order to receive and maintain accreditation.
  - Although item 13876 may appear to incentivise overuse of invasive pressure monitoring, there is no evidence that this risk has materialised. Invasive pressure monitoring allows real time adjustments of physiological parameters, enabling organ perfusion to be maximized to provide patients with the best chance of recovery. However, all invasive lines are associated with risk of complications that necessitate removal when no longer required.

Δ To date, an alternative and superior way of accounting for differences in patient complexity has not been identified. The Committee noted the following:

- Bundling an average requirement for invasive pressure monitoring into items 13870 and 13873 would result in an inappropriate funding transfer from facilities with high-complexity case-mixes to facilities with low-complexity case-mixes.
- Disease severity scoring systems are not a viable method of accounting for differences in patient complexity as they do not provide an accurate reflection of the level of professional involvement required.
  - For example, the Acute Physiology and Chronic Health Evaluation (APACHE) is only validated for use as an admission score (in the first 24 hours in ICU). The physiological parameters are not a meaningful indicator of the level of clinical input required once these parameters are being maintained by clinical interventions.
- Indication-based items—for example, those based on major diagnostic categories (such as major cardiac surgery), similar to the MBS Relative Value Guide for anaesthetics items—are both complex and inadequate. Such a system would require providers to use a significantly larger number of items, as well as requiring the MBS to maintain these items. Although these items may adequately account for case-mix variation between facilities, it is likely that the categories would not be able to account for provider-level case-mix variation.
- International approaches do not offer alternatives that adequately account for complexity whilst also addressing the perceived potential for incentivising over-servicing.
  - In the United States, both Medicare and commercial payors use current procedural terminology (CPT) codes on a fee-for-service basis, with critical care attendance items tiered by time, and additional procedures billed via separate codes (for example, for ventilation or insertion of extracorporeal membrane oxygenation [ECMO] cannulae).
  - In Canada, both Ontario and British Columbia use per-diem payments.
  - In the United Kingdom, National Health Service Physicians are salaried staff.
  - In New Zealand, ICU services are provided in public hospitals by salaried Intensive Care Physicians.

Figure 5: Use of item 13876 in conjunction with ICU daily management items 13870 and 13873



	Rank	Item No.	Co-claimed %	Co-claimed item description
13870 Manage-ment of a patient in ICU, first day	1	13876	75%	Invasive pressure monitoring in ICU
	2	13882	31%	Ventilatory support, management of in ICU
	3	13842	5%	Intra-arterial cannulation for blood gas analysis
	4	13706	5%	Transfusion of blood or bone marrow already collected
	5	13815	4%	Central vein catheterisation, item 13318 applies
	6	13881	3%	ICU airway access and initiation of mechanical ventilation
	7	11503	1%	Measurement of respiratory system function
	8	18225	1%	Infusion for anaesthesia or analgesia > 15 mins
	9	66581	1%	Blood gas quantitation - 6 or more specimens in a day
	10	13885	1%	Continuous haemofiltration, in ICU, first day
13873 Manage-ment of a patient in ICU, subsequent days	1	13876	69%	Invasive pressure monitoring in ICU
	2	13882	30%	Ventilatory support, management of in ICU
	3	13706	4%	Transfusion of blood or bone marrow already collected
	4	13888	3%	Continuous haemofiltration, in ICU, subsequent day/s
	5	11503	2%	Measurement of respiratory system function
	6	13830	1%	Intracranial pressure, monitoring of
	7	66581	1%	Blood gas quantitation - 6 or more specimens in a day
	8	13815	1%	Central vein catheterisation, item 13318 applies
	9	18225	1%	Infusion for anaesthesia or analgesia > 15 mins
	10	13842	1%	Intra-arterial cannulation for blood gas analysis

SOURCE: MBS010 co-claiming data for month of July 2015

5.3 Management of counterpulsation by intraaortic balloon (items 13847 and 13848)

Table 6: Item introduction table for items 13847 and 13848

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13847	Counterpulsation by intraaortic balloon management on the first day including initial and subsequent consultations and monitoring of parameters. (Anaes.)	$156.10	298	$34,874	-0.1%
13848	Counterpulsation by intraaortic balloon management on each day subsequent to the first, including associated consultations and monitoring of parameters.	$131.05	781	$76,678	-0.8%

Recommendation 4

- Δ Remove the differential fees for the first day and subsequent days of managing counterpulsation by intraaortic balloon:

  – Remove item 13847 (for the management of counterpulsation by intraaortic balloon on the first day) from the MBS.

  – Revise item 13848 (for the management of counterpulsation by intraaortic balloon on each day subsequent to the first) to apply to management on any day (including the first).

The proposed item descriptor and explanatory notes are provided below.

Item 13848

COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day, including associated consultations and monitoring of parameters.

Explanatory note for item 13848:

Item 13858 covers management of counterpulsation by intraaortic balloon and includes initial and subsequent consultations and monitoring of parameters. "Management" of counterpulsation of intraaortic balloon means full haemodynamic assessment and management on several occasions during the day.

Insertion of the intraaortic balloon is covered under item 38609.

Rationale

This recommendation focuses on enhancing value for the patient and the health system, and on simplifying the MBS. It is based on the following observation.

- Δ There is no significant difference in the amount of clinical input required on the first day and on subsequent days of management, other than that already reflected in the separate item covering insertion of an intraaortic balloon pump (item 38609).

5.4 Circulatory support items (13851 and 13854) and coverage of ventricular assist devices and extracorporeal life support

Table 7: Item introduction table for items 13851 and 13854

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13851	Circulatory support device, management of, on first day.	$493.65	103	$38,181	12.2%
13854	Circulatory support device, management of, on each day subsequent to the first.	$114.85	656	$57,204	14.6%

Recommendation 5

- Δ Consider an expedited MSAC assessment for listing MBS items for extracorporeal life support.

The proposed item descriptors and explanatory notes are provided below.

– For veno-arterial cardiopulmonary extracorporeal life support:

Item AAAAA:

Peripheral Cannulation for Veno-arterial Cardiopulmonary Extracorporeal Life Support, including any use of imaging to assist in the procedure.

Item BBBBB:

Veno-arterial Cardiopulmonary Extracorporeal Life Support, management of, on the first day.

Item CCCCC:

Veno-arterial Cardiopulmonary Extracorporeal Life Support, management of, on each day subsequent to the first.

– For veno-venous pulmonary extracorporeal life support:

Item XXXXX:

Peripheral Cannulation for Veno-venous Pulmonary Extracorporeal Life Support, including any use of imaging to assist in the procedure.

Item YYYYY:

Veno-venous Pulmonary Extracorporeal Life Support, management of, on the first day.

Item ZZZZZ:

Veno-venous Pulmonary Extracorporeal Life Support, management of, on each day subsequent to the first.

Explanatory notes

Items AAAAA, BBBBB, CCCCC, and items XXXXX, YYYYY and ZZZZZ cover extracorporeal life support in an ICU. Benefits are payable only once per calendar day for a patient, irrespective of the number of medical practitioners involved.

Δ Revise items 13851 and 13854 to clarify that they are intended to cover ventricular assist devices (VADs), but only if and when MBS items are introduced for extracorporeal life support.

Item descriptors and explanatory notes are provided below.

Item 13851:

Ventricular Assist Device, management of, on first day, where the ICU admission relates to device implantation or complication.

Item 13854:

Ventricular Assist Devices, management of, on a day subsequent to the first, where the ICU admission relates to device implantation or complication.

Explanatory notes for items 13851 and 13854:

Items 13851 and 13854 cover the management of ventricular assist devices in an ICU. Benefits are payable only once per calendar day for a patient, irrespective of the number of medical practitioners involved.

Rationale

This recommendation focuses on making item descriptors clearer and supporting access to best-practice health services. It is based on the following observations.

- Items 13851 and 13854 were originally introduced to cover management of VADs. However, the items are vaguely worded and are currently used to cover ECMO services. The items could be misinterpreted as covering other circulatory support devices (such as intra-aortic balloon pumps, which are already covered under MBS items 13847 and 13848).
- The Committee noted that extracorporeal life support through ECMO is an established clinical procedure currently in use in Australia. The procedure is not experimental or novel. However, the evidence for use is indication-specific. As such, the MSAC may wish to review these indications and modify the proposed item descriptors accordingly.
- The level of clinical input required for the management of an ICU patient does not necessarily differ significantly for a patient with a VAD (for example, in the case of a long-term implanted VAD). The circulatory support items 13851 and 13854 should therefore only be used if the clinical issue requiring ICU admission relates in some way to management of the VAD.
- Veno-arterial extracorporeal life support is considerably more complex to manage than veno-venous extracorporeal life support, particularly in the weaning stage of therapy, due to embolic and ischemic risks, among others.

5.5 Vascular catheterisation items (13815 and 13842) and use of ultrasound

Table 8: Item introduction table for items 13815, 13839 and 13842

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13815	Central vein catheterisation by percutaneous or open exposure not being a service to which item 13318 applies. (Anaes.)	$85.25	18,523	$1,203,563	9.7%
13839	Arterial puncture and collection of blood for diagnostic purposes.	$23.05	9,850	$189,830	1.1%
13842	Intra-arterial cannulation for the purpose of taking multiple arterial blood samples for blood gas analysis.	$69.30	6,896	$359,476	8.5%

Recommendation 6

- The Committee requests that the MBS Review Taskforce and Diagnostic Imaging Clinical Committee consider making recommendations to revise item descriptors for item 13815 (for central vein catheterisation) and item 13842 (for intra-arterial cannulation) to include the following text: “under ultrasound guidance, where clinically appropriate.”
  - MBS benefits for ultrasound services should not be payable separately from items 13815 and 13842.
  - The above should apply to all providers, regardless of specialty.
- Leave item 13839 unchanged.

Rationale

These recommendations focus on supporting best-practice health services and enhancing value for patients and the community. They are based on the following observations.

- Where used, ultrasound guidance is an integral component of the services covered by items 13815 and 13842, and it should not be separately billed.
  - Although clinical practice is evolving to include ultrasound as part of the standard of care, mandatory use of ultrasound may not provide value for patients or the health system in instances where insertion without ultrasound guidance is equally safe. Specifically, there is poorer evidence regarding the value of ultrasound use for experienced operators.
  - There is no significant difference in the service provided between Intensivists, Emergency Physicians and other appropriately qualified provider types.
- The Committee agreed that MBS benefits for arterial puncture and the collection of blood for diagnostic purposes (item 13839) and intra-arterial cannulation for blood gas analysis (item 13842) did not need to be amended.
  - At present, MBS benefits for arterial puncture and the collection of blood for diagnostic purposes (item 13839) are not payable separately from ICU daily management items (13870

and 13873) as the services are bundled. However, intra-arterial cannulation for blood gas analysis (item 13842) is not bundled and MBS benefits remain payable separately.

- The explanatory notes for ICU daily management items state: "Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day."
- The Committee agreed that arterial puncture and the collection of blood for diagnosis purposes is a common procedure in the ICU, and it remains integral to the standard of care. The Committee therefore concluded that MBS benefits should not be payable separately, in line with current item specifications.
- The Committee also agreed that intra-arterial cannulation for blood gas analysis represents a distinct and substantive procedure requiring special skill, and that it should therefore continue to attract separate MBS benefits. The service is not routinely performed (Figure 6).

Figure 6: Use of item 13842 in conjunction with ICU daily management items 13870 and 13873

Item 13842 (intra-arterial cannulation for blood gas analysis)

Items most commonly co-claimed with ICU daily management items

	Rank	Item No.	Co-claimed %	Co-claimed item description
13870 Manage-ment of a patient in ICU, first day	1	13876	75%	Central venous pressure, monitoring in ICU
	2	13882	31%	Ventilatory support, management of in ICU
	3	13842	5%	Intra-arterial cannulation for blood gas analysis
	4	13706	5%	Transfusion of blood or bone marrow already collected
	5	13815	4%	Central vein catheterisation, item 13318 applies
	6	13881	3%	ICU airway access and initiation of mechanical ventilation
	7	11503	1%	Measurement of respiratory system function
	8	18225	1%	Infusion for anaesthesia or analgesia > 15 mins
	9	66581	1%	Blood gas quantitation - 6 or more specimens in a day
	10	13885	1%	Continuous haemofiltration, in ICU, first day
13873 Manage-ment of a patient in ICU, subsequent days	1	13876	69%	Central venous pressure, monitoring in ICU
	2	13882	30%	Ventilatory support, management of in ICU
	3	13706	4%	Transfusion of blood or bone marrow already collected
	4	13888	3%	Continuous haemofiltration, in ICU, subsequent day/s
	5	11503	2%	Measurement of respiratory system function
	6	13830	1%	Intracranial pressure, monitoring of
	7	66581	1%	Blood gas quantitation - 6 or more specimens in a day
	8	13815	1%	Central vein catheterisation, item 13318 applies
	9	18225	1%	Infusion for anaesthesia or analgesia > 15 mins
	10	13842	1%	Intra-arterial cannulation for blood gas analysis

SOURCE: MBS010 co-claiming data for month of July 2015

5.6 An item for goals-of-care services provided by Intensive Care Physicians

Recommendation 7

Δ Introduce an MBS item for the discussion and documentation of goals of care by an Intensive Care Specialist.

The proposed item descriptors and explanatory notes are provided below.

Item ABCD1:

Professional attendance by an Intensive Care Specialist for the discussion and documentation of goals of care:

(a) For a patient

i. Experiencing either a life-threatening acute illness, or an acute illness in the context of a high baseline risk for end-of-life within the next 12 months, and

ii. For whom alternatives to active management are reasonably thought to be an appropriate clinical choice, and

iii. For whom an appropriate documentation of goals of care does not already exist or these goals are reasonably expected to change substantially due to new clinical circumstances;

(b) Including

i. Assessment of the patient's capacity to make goals of care decisions, and

ii. Comprehensive evaluation of the patient's medical, physical, psychological and social issues, including identification of major issues requiring goals of care to be defined, and

iii. **Discussion** with the patient (or surrogate), **which must include proactive offering of treatment alternatives**, including alternatives to intensive or escalated care; and, where appropriate, with the patient's family, carers and other health practitioners, and

iv. **Agreement on the goals of care**, between the provider and the patient or their guardian, and in relation to all major medical issues identified in the comprehensive assessment, and

v. **Documentation** of the goals of care in a way that facilitates timely retrieval by subsequent healthcare providers for the patient, and includes what interventions should and should not be pursued, with

vi. **At least 60 minutes** of dedicated professional involvement;

(c) Claimable

i. **Once only per inpatient admission** (including instances of use of corresponding items 51K and 51L), unless precipitated by a subsequent ICU referral or Cardiac Arrest / Medical Emergency Team ("MET") call where the clinical circumstances change substantively with a resultant expectation that the original goals of care require amendment,

ii. **For the medical practitioner taking overall responsibility** for the agreement and documentation of goals of care.

Explanatory notes for items ABCD1:

(a) *Patients could be assessed for "high baseline risk" (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the SPICT tool.*

(b) *"Proactive offering of treatment alternatives" means that the patient must be provided with reasonable alternatives to continued intensive / active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).*

(c) *"Documentation" should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.*

(d) *Providers of this service should be appropriately trained to provide end-of-life care options and goals of care discussions.*

(e) *The item should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.*

Rationale

This recommendation focuses on supporting access to a best-practice health service that improves both the patient experience and enhances the value provided to the patient and the health system. It is based on the following observations.

- The Committee noted that efforts to define a patient's goals of care are inconsistent and are often undertaken at a later stage than is clinically useful.
  - Patients attended by Intensive Care Specialists often have not had goals of care defined in advance by their primary GP or their in-hours "home team."
  - The lack of advance decision-making on goals of care may result in over-treatment and / or excessive lengths of stay. In particular, there are patients who may not wish to proceed with active treatment but may feel that they have not been given alternative options to consider.
- As a result, the Committee agreed that Intensive Care Physicians often bear responsibility for initiating discussion regarding the goals of care. These discussions occur upon referral to the ICU, or on hospital wards where an Intensive Care Specialist is requested to review the clinically deteriorating patient (for example, during a MET call or cardiac arrest call). The professional involvement required in such situations is significant due to the:
  - Acuity of the situation.
  - Importance of clarifying the goals of care prior to admission to the ICU, particularly where such an admission may be inappropriate.
  - Need to undertake complex discussions and decision-making for a patient with whom the provider is unfamiliar.
- Based on these observations, the Committee felt that there is a need for the MBS to better support discussion and documentation of goals of care in two situations:
  - Prior to presentation in an ED or referral to an ICU.
  - When Intensive Care and Emergency Physicians are required to undertake goals of care discussion and documentation because this has not previously occurred and an acutely unwell patient may otherwise embark on an undesirable course of intensive treatment (for example, surgery or admission to an ICU).

The Committee focused on the latter situation, but it supports the efforts of other Clinical Committees involved in the MBS Review to address the former situation.

6. General recommendations and comments

The following recommendations were developed by the Committee and accepted unanimously.

6.1 Gastric lavage item (14200)

Table 9: Item introduction table for item 14200

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
14200	Gastric lavage in the treatment of ingested poison.	$59.80	15	$746	-12.9%

Recommendation 8

Δ Remove item 14200 from the MBS.

Rationale

This recommendation focuses on ensuring patient safety and supporting best-practice health services. It is based on the following observation.

- Δ There is clinical consensus (based on the available evidence) that this is an unsafe practice. Removing this rarely used item is expected to have minimal impact on patient access and minimal cost impact on the MBS, with only $797 paid in MBS benefits in FY2014/15 for 16 services (declining at a five-year compound annual growth rate of -11 per cent).

6.2 An MBS item for rapid response system / code blue attendance services

Recommendation 9

Δ Consider an expedited MSAC assessment for listing an MBS item for rapid response system / code blue attendances.

The proposed item descriptor and explanatory notes are provided below.

Item ABCD2:

Professional attendance by a specialist or consultant physician on a patient in a private hospital, outside an Emergency Department or Intensive Care Unit, involving rapid response to a referral made by a registered health practitioner, such as in response to an arrest or medical emergency team ("MET") call or code blue.

Including assessment of the patient, investigation and management, and all procedures performed in conjunction with such an attendance (such as rapid IV access, administration of fluid, vasopressors, point-of-care ultrasound, central line access, and ventilation).

Claimable only by the medical practitioner taking overall responsibility for the patient in the course of the call or code response.

Not claimable in conjunction with items 13870, 13873, ED attendance items, or the goals of care item by the same provider.

Rationale

This recommendation focuses on supporting access to best-practice health services. It is based on the following observations.

- The Committee acknowledged that medical professional attendances for arrest calls and rapid response system alerts (such as MET calls) represent the best-practice standard of care.
- Significant professional involvement is required when attending to such patients—over and above other referred attendances—because the patient is unknown to the provider, the patient is in an unstable clinical condition or is critically ill, and the provider needs to attend immediately (disrupting his or her existing workflow). The amount of professional involvement required is similar to the complex ED attendance item in conjunction with the resuscitation add-on item.
- If the patient is subsequently transferred to the ED or ICU under the care of the same provider, MBS benefits for the provider's professional involvement are payable under the ED attendance items and add-ons or the ICU daily management items (13870 and 13873), respectively.

6.3 Items for which no concerns were raised

Table 10: Item introduction table for items 13818, 13830, 13857 and 13881–13888

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement. (Anaes.)	$113.70	338	$29,020	-5.9%
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician – each day.	$75.35	2,208	$124,877	6.7%
13857	Airway access, establishment of; and initiation of mechanical ventilation (other than in the context of an anaesthetic for surgery), outside of an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit.	$146.40	521	$59,356	3.2%
13881	Airway access, establishment of; and initiation of mechanical ventilation, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support. (H)	$146.40	4,283	$470,270	0.7%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
13882	Ventilatory support in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day. (H)	$115.25	80,099	$6,924,367	2.7%
13885	Continuous arterio-venous or veno-venous haemofiltration, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care – on the first day. (H)	$153.65	1,301	$149,929	5.8%
13888	Continuous arterio-venous or veno-venous haemofiltration, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care – on each day subsequent to the first day. (H)	$76.90	6,050	$349,066	4.8%

Recommendation 10

Δ Leave items 13818, 13830, 13857 and 13881–13888 unchanged.

Rationale

This recommendation is based on the following observations.

Δ No concerns were raised regarding access to these items or the safety, obsolescence, value or misuse of these items.

- Right heart balloon catheter insertion (item 13818) was recently the subject of an MSAC review. The low usage pattern reflects specialised use by those with the particular skill (for example, it is used in some post-cardiac surgical patients) and is not an indicator of item obsolescence.
- The item for intracranial pressure monitoring (item 13830) is rarely used and is at low risk of misuse. The service is indicated in a specific and well-defined patient population, and providers are typically vigilant in ensuring that intracranial pressure monitoring lines are removed as quickly as possible.

- The distinction between first and subsequent days in items 13885 and 13888 (continuous hemofiltration management in ICU) should be retained as this accurately reflects variation in effort involved (which is greater on the first day).

6.4 Remuneration of Emergency Physicians

Δ The Committee noted that the overall level of remuneration for Emergency Physicians providing services in private EDs is not commensurate with the professional involvement required. Specifically, it does not recognise that emergency medicine is characterised by:

- A higher proportion of afterhours / unsociable-hours work than other medical professionals.
- A high-intensity environment.
- A higher average number of work hours per week (approximately 53 hours) than most other medical specialties.
- Resultant high burnout rates.

7. Stakeholder impact statement

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

8. References

1. Elshaug A. Appropriate Use Criteria. 2016.

Appendix A - Index of items

Item #	Recommendation	Page #
501	Change	16
503	Change	16
507	Change	17
511	Change	17
515	Change	18
519	Change	18
520	Change	19
530	Change	19
532	Change	19
534	Change	19
536	Change	19
13815	Change	40
13818	Leave unchanged	46
13830	Leave unchanged	46
13839	Leave unchanged	40
13842	Change	40
13847	Delete	36
13848	Change	36
13851	Change	38
13854	Change	38
13857	Leave unchanged	46
13870	Leave unchanged	33
13873	Leave unchanged	33
13876	Leave unchanged	35
13881	Leave unchanged	46
13882	Leave unchanged	48
13885	Leave unchanged	48
13888	Leave unchanged	48
14200	Delete	45

Appendix B - Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

Section 4: Emergency medicine recommendations: Recommendation 1, Recommendation 2 and Recommendation 2.1

Item(s)	What it does	Committee recommendation	What would be different	Why
501–536	These items cover instances where an Emergency Physician attends to a patient in a recognised ED at a private hospital. These attendances involve the unscheduled evaluation and management of a patient with an unknown diagnosis. The Emergency Physician typically does not know the patient. The first five items (501–515) cover attendances with different levels of complexity (Levels 1 to 5). The remaining six items (519–536) cover prolonged attendances for critically ill patients with immediately life-threatening problems (requiring resuscitation). They are tiered by time into six categories: up to one hour, two hours, three hours, four hours or five hours, and five or more hours.	Restructure ED attendance items into three tiered base items with add-on items. The three base items reflect the differing levels of professional involvement required in ED attendances, including the amount of time required and the complexity of the medical problem (based on the number of diagnoses and medical problems that require consideration). The add-on items reflect the significant additional professional involvement needed for additional issues or tasks, such as managing a fracture or helping to define goals of care for a patient potentially nearing the end of his or her life. These add-on items are to be used instead of other MBS items. Use a consistent item framework for all emergency attendances, regardless of what type of medical provider attends to the patient. Item descriptions for ED attendances in accredited	Patients would receive similar MBS benefits for similar services, rather than benefits that differ based on how providers interpret MBS item descriptions. Patients receiving ED attendance services will consistently be billed using ED attendance items, rather than a different set of items depending on whether the medical practitioner is an Emergency Medicine Specialist or otherwise.	This recommendation is intended to ensure that the ED attendance items accurately reflect the key factors that determine the amount of provider skill, time and risk involved. It does so by making the item descriptors clearer, which provides patients with greater billing transparency, reduces variability in item use for similar services and supports ease of auditing. This recommendation focuses on making billing more transparent for patients and providers, and ensuring that patients have equal access to the same MBS benefits for ED attendances if they receive the same services.

Item(s)	What it does	Committee recommendation	What would be different	Why
		private EDs should specify the provider type and applicable schedule fee but should otherwise be the same. – The MBS benefit should be lower if the provider is not an Emergency Medicine Specialist. The benefit amount should be a fixed proportion of the benefit available for services provided by Emergency Medicine Specialists.		

Section 5: Intensive care recommendations: Recommendation 3 to Recommendation 7

Item(s)	What it does	Committee recommendation	What would be different	Why
13870, 13873, 13876	These items cover the provision of intensive care to a patient in an ICU. This includes both professional attendances by medical providers and routine procedures such as electrocardiographic (ECG) monitoring, sampling blood from arteries for testing and inserting a bladder catheter to drain urine, whether on the patient's first day in an ICU (13870) or on subsequent days (13873). There is a separate item that covers the management of invasive blood pressure monitoring by devices ('catheters' known also as 'lines') inserted into arteries and / or veins in	Leave these items unchanged.	No changes.	There is no evidence that these items or services are being misused, and they accurately reflect modern intensive care practices. In particular, the Committee believes that the need for invasive blood pressure monitoring remains the most appropriate way of accounting for different levels of patient complexity in an ICU for the following reasons: Δ It is scalable (from no invasive pressure monitoring up to four types of monitoring), simple and auditable, and it accurately reflects the overall

Item(s)	What it does	Committee recommendation	What would be different	Why
	or near the heart and lungs (13876), for each type of pressure monitored up to a maximum of four pressures in a day. Intensive care patients who are less well or have more complex needs typically require more monitoring due to unstable blood circulation.			level of professional involvement required. Δ There are no appropriate alternatives, and invasive pressure monitoring is likely to be less ambiguous than alternative ways of accounting for complexity. This means that there is less risk of item misuse.
13847, 13848	'Counterpulsation by intraaortic balloon' uses a therapeutic device to support the function of the heart. The device alternates between: (i) creating a vacuum effect (by rapidly deflating the balloon) that pulls blood forward during contraction of the heart; and (ii) maintaining blood pressure (by inflating the balloon) in between contractions of the heart.	Remove the different fees for managing counterpulsation by intraaortic balloon on the first day (13847) and on subsequent days (13848).	The same MBS benefit would be provided on the first day and subsequent days of managing counterpulsation by intraaortic balloon.	This recommendation simplifies the MBS and enhances value for the patient and the health system because it recognises that there is no significant difference in the professional involvement required between first and subsequent days.
13851, 13854	These items cover management of a therapeutic device that helps the heart to circulate blood around the body, either on the first day of care (13851) or on subsequent days (13854). It may be used if the heart is injured and unable to adequately supply the body with blood (for example, during a severe heart attack). Different types of device are available, including intra-aortic balloon pumps (IABP; which are also covered under	Consider an expedited MSAC assessment for listing new MBS items for extracorporeal life support, and revise items 13851 and 13854 to clarify that they are intended to cover ventricular assist devices (VADs).	The currently item descriptors are ambiguous. The new descriptors will clearly refer to the intended service of managing ventricular assist devices. The MSAC will consider listing ECMO on the MBS. If it decides to list ECMO, MBS benefits will be available for ECMO and	This recommendation focuses on making the currently ambiguous item descriptors for items 13851 and 13854 clearer. It will also ensure that substantively different technologies (such as ECMO) are appropriately evaluated by the MSAC before being listed as a distinct service (item) on the MBS.

Item(s)	What it does	Committee recommendation	What would be different	Why
	items 13847 and 13848); ventricular assist devices (which are the intended device covered under items 13851 and 13854); and extracorporeal membrane oxygenation (ECMO; a more recently developed device that supports the functions of the lungs in addition to the functions of the heart).		other extracorporeal life support services under a specific item.	
13815, 13842	Cannulation and catheterisation of arteries (13842) or veins (13815) is a procedure that involves inserting a tube ('catheter' or 'cannula') into a blood vessel. This tube allows fluids to be delivered, blood to be drawn or blood pressure to be measured. The tube can be inserted with or without ultrasound guidance. Ultrasound guidance allows the provider to visualise the structures beneath the skin (such as blood vessels, nerves and muscles). This helps the provider to guide the tube into position.	Revise the item descriptions for intra-arterial cannulation (13842) and central vein catheterisation (13815) to encourage providers to use ultrasound guidance.	Item descriptors would clearly convey the expectation that ultrasound guidance should be used where clinically appropriate. This would encourage providers to deliver this service safely and effectively.	This recommendation supports the safe and effective delivery of health services and enhances value for patients and the community. Ultrasound guidance helps providers to accurately insert catheters or cannulae into blood vessels without damaging the surrounding areas. In modern practice, the use of ultrasound guidance is considered best practice, and it is therefore an integral component of cannulation and catheterisation. For this reason, it should not attract separate MBS benefits. However, a blanket requirement for ultrasound guidance is not appropriate, because there are circumstances where ultrasound guidance is not appropriate or necessary. For example, experienced providers may not need it, especially if they were trained before ultrasound

Item(s)	What it does	Committee recommendation	What would be different	Why
				became part of the standard of care.
TBD	Defining goals of care is a medical professional attendance service. It involves a comprehensive evaluation of the patient's issues (medical, psychological, social and other); proactive offering of treatment alternatives (including alternatives to intensive or escalated care); and discussion of these alternatives with the patient (or surrogate decision maker), and the patient's family, carers and other health practitioners (where appropriate).	Introduce an MBS item that covers discussion and documentation of goals of care by an Emergency Physician or Intensive Care Specialist for patients who are potentially nearing the end of their lives, where alternatives to active management may be an appropriate clinical choice, and where relevant goals of care have not yet been decided.	MBS benefits would be payable for this service, under a specific item.	This recommendation focuses on improving the quality of end-of-life decision-making, with the aim of improving patient experience and enhancing value for the patient and the community. The Committee noted consumer feedback that end-of-life decisions are often made without providing sufficient information to patients and their families on the alternatives available to them. Patients may not realise they have alternative options, which may result in them receiving prolonged and futile treatment that they do not want. The Committee noted that in ideal circumstances, goals of care are defined with a provider who is familiar with the patient, prior to admission to hospital or an ICU. However, if this has not happened, it is important that providers support patients and their families in making informed choices before beginning intensive and potentially prolonged treatment.

Section 6: General recommendations: Recommendation 8 to Recommendation 10

Item(s)	What it does	Committee recommendation	What would be different	Why
14200	'Gastric lavage' is a therapeutic procedure (also known colloquially as 'stomach pumping') that is used to treat patients who have ingested poison. A tube is passed into the stomach, and small amounts of fluid are then passed in and out of the stomach (repeatedly) to remove the poison.	Remove this item from the MBS.	This service would no longer attract an MBS rebate.	Gastric lavage is no longer best practice. It has unclear benefits, particularly in comparison to other readily available and less invasive techniques. There is also a risk of serious complications. It is therefore considered an obsolete and unsafe practice.
TBD	Response to a 'code blue' or rapid response system referral is a medical professional attendance service. 'Code blue' calls are requests for immediate medical professional attendance for medical emergencies, such as cardiac arrest. Rapid response systems, such as the Medical Emergency Team (MET) call system, are designed to request immediate medical professional attendance to manage patients whose health is deteriorating. The aim is to intervene early in order to stabilise the patient and prevent further deterioration that results in ICU admission or cardiac arrest. The service involves immediate attendance, where the provider assesses the patient, investigates the medical emergency and manages care. This includes performing procedures such as rapid administration of fluid and medications to maintain blood pressure	Consider an expedited MSAC assessment for listing an MBS item for rapid response system / code blue attendances.	MBS benefits would be payable for this service, under a specific item.	This recommendation focuses on supporting access to this best-practice health service in order to improve patient health outcomes. Δ Medical professional attendances for arrest calls and rapid response system alerts (such as MET calls) represent best-practice standard of care and are potentially life-saving. Δ Significant professional involvement is required when attending to such patients—over and above other referred attendances that may be covered under existing item 104—because the provider does not know the patient, the patient is in an unstable clinical condition or is critically ill, and the provider needs to attend immediately (disrupting his or her existing workflow).

Item(s)	What it does	Committee recommendation	What would be different	Why
	and flow, as well as procedures to support the patient's breathing. This proposed item is for attendances in response to code blue or rapid response system requests outside of EDs or ICUs by the medical practitioner taking overall responsibility for the patient in the course of the call or code response. It is not claimable in conjunction with ED attendance or ICU daily management items by the same provider.			
13818, 13830, 13857 and 13881–13888	These items refer to a variety of procedural services. Δ Item 13818: 'Right heart balloon catheters' are devices inserted into the part of the heart responsible for receiving blood from the body and pumping it to the lungs. These devices measure blood flow and pressures, such as to monitor patients who have received heart surgery. Δ Item 13830: 'Intracranial pressure monitoring' is a specialized service involving measurement of the pressure within the skull, such as to monitor patients who have experienced head trauma or surgery on the brain. Δ Items 13857 and 13881: 'airway access and mechanical ventilation' is	Leave these items unchanged.	No changes.	No concerns were raised regarding access to these items or the safety, obsolescence, value or misuse of these items.

Item(s)	What it does	Committee recommendation	What would be different	Why
	a therapeutic procedure involving insertion and use of devices to support a patient's lung function (breathing). Δ Item 13885 and 13888: 'haemofiltration' is a therapeutic procedure that supports a patient's kidney function (for example, removal of waste products from blood, and maintenance of blood concentrations of electrolytes).			

Appendix C - Glossary

Term	Description
ACEM	Australasian College for Emergency Medicine
APACHE	Acute Physiology and Chronic Health Evaluation
APED	Approved Private Emergency Department
ANZICS	Australian and New Zealand Intensive Care Society
ASUM	Australasian Society for Ultrasound in Medicine
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
CCPU	Certificate in Clinician Performed Ultrasound
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).
CLABSI	Catheter-associated blood stream infection
CPT codes	Current procedural terminology codes
CORE	ANZICS Centre for Outcome and Resource Evaluation
DDU	Diploma in Diagnostic Ultrasound
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
ECG	Electrocardiograms
ECMO	Extracorporeal Membrane Oxygenation
ED	Emergency Department
EDWG	Emergency Medicine Working Group of the Intensive Care and Emergency Medicine Clinical Committee
EoLWG	End-of-Life Care Working Group of the Intensive Care and Emergency Medicine Clinical Committee
FACEM	Fellow of the Australasian College for Emergency Medicine
FAST	Focused assessment with sonography for trauma
FY	Financial year
GP	General Practitioner
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.
ICU	Intensive Care Unit
ICUWG	Intensive Care Working Group of the Intensive Care and Emergency Medicine Clinical Committee

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.
MET	Medical Emergency Team
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.
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).
Non-VRGP	Non-Vocationally Registered General Practitioner
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 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
SSU	Short Stay Unit
The Committee	The Intensive Care and Emergency Medicine Clinical Committee of the MBS Review
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.
VAD	Ventricular assist device
VRGP	Vocationally Registered General Practitioner

Appendix D - End-of-Life Care Working Group membership

The Committee formed a Working Group to consider end-of-life care services. The End-of-Life Care Working Group (EoLWG) included the members listed in Table 11.

Table 11. End-of-Life Care Working Group members

Name	Position/Organisation	Interests declared
Dr Michael Ben-Meir* (Chair)	Director, Emergency Department, Cabrini Health Chair, Private Practice Committee, Australasian College for Emergency Medicine	None
Dr Andrew Holt	Deputy Director and Supervisor of Training, Department of Critical Care Medicine, Flinders Medical Centre Director, Critical Care Unit, Flinders Private Hospital Director, Intensive Care Unit, Ashford Hospital Director, South Australian Home Parenteral Nutrition Unit Senior Lecturer, School of Medicine, Flinders University Chairman, Medical Advisory Committee, Adelaide Community Healthcare Alliance	None
A/Prof Andrew Turner	Director, Department of Critical Care Medicine, Royal Hobart Hospital	None
Ms Eileen Jerga AM*	Consumer Representative	None
Dr Matthew Anstey*	Intensive Care Specialist and Director of ICU Research, Sir Charles Gairdner Hospital Medical Advisor, Australian Commission on Safety and Quality in Health Care Board Member, Choosing Wisely Australia	None
Dr William Lukin	Staff Specialist, Emergency Medicine, Royal Brisbane & Women's Hospital Advanced Trainee in Palliative Medicine, Royal Brisbane & Women's Hospital	None
Prof Imogen Mitchell	Acting Dean, Medical School, Australian National University Staff Specialist Intensive Care Unit, Canberra Hospital Organisational Unit Member, Canberra Hospital Campus Organisational Unit Member, Acton Campus Researcher, Critical Care and Emergency Medicine	None
Prof Ken Hillman	Head, Department of Physiology and Sleep Medicine, Sir Charles Gardiner Hospital Clinical Professor, University of Western Australia	None

Name	Position/Organisation	Interests declared
Dr Philip Hungerford	Clinical Superintendent, Tamworth Rural Referral Hospital Former Director of Critical Care, Tamworth Rural Referral Hospital Emergency Specialist and Palliative Care Clinician	None
A/Prof Sally McCarthy (Committee Chair)*	Senior Emergency Physician, Prince of Wales Hospital Medical Director, Emergency Care Institute NSW Clinical Lead, NSW Whole of Hospital Program NSW Health Former President, Australasian College for Emergency Medicine	None

*Also a member of the Committee.

It is noted that the majority of 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.

The EoLWG developed recommendations regarding the provision of services by Emergency and Intensive Care Specialists in relation to defining goals of care for patients. These recommendations are included in Section 4.2 – Emergency Department attendance items and Section 5.6 – An item for goals-of-care services provided by Intensive Care Physicians. The Committee unanimously endorsed the recommendations.