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# **Medicare Benefits Schedule Review Taskforce**

## **Report from the Renal Clinical Committee**

**December 2016**

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## 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 and improves health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

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

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

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The 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 recommendations from the Clinical Committees are released for stakeholder consultation. The Clinical Committees will consider feedback from stakeholders and then provide recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for Health, for consideration by Government.

## 1.1 MBS Review process

The Taskforce has endorsed a process whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce asked all committees in the second tranche of the Review process to review MBS items using a framework based on Appropriate Use Criteria accepted by the Taskforce(1). This framework includes the following steps: (i) review data and literature relevant to the items under consideration; (ii) identify MBS items that are potentially obsolete, are of questionable clinical value, are misused and/or pose a risk to patient safety; and (iii) develop and refine recommendations for these items, based on the literature and relevant data, in consultation with relevant stakeholders. In complex cases, full appropriate use criteria were developed for an item's descriptor and explanatory notes. All second-tranche committees involved in this Review adopted this framework, which is outlined in more detail in Section 2.3.

The recommendations from the Clinical Committees will be released for stakeholder consultation. The Clinical Committees will consider feedback from stakeholders and then provide recommendations to the Taskforce in Review reports. The Taskforce will consider the Review reports from Clinical Committees, along with stakeholder feedback, before making recommendations to the Minister for Health for consideration by the Government.

## 1.2 The Renal Clinical Committee

The Renal Clinical Committee (the Committee) was established in April 2016 to make recommendations to the Taskforce regarding MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. The Taskforce asked the Committee to review renal-related items.

The Committee was assigned seven items to review, all relating to initiation and supervision of haemodialysis and peritoneal dialysis. In 2014/15 these items combined provided for 97,864 services and \$6.8 million in benefits. The average growth in services is 5.8 per cent per year, though item 13103 for supervision of dialysis accounts for 78 per cent of services and is growing at 8.1 per cent per year. There were 12,000 patients on dialysis in Australia in 2014/15, of which approximately 4,400 received dialysis supervision services under the MBS. There are an estimated 3,600 patients currently receiving home dialysis of which, 73 per cent (n=2,663) claimed supervision (item 13104 planning and management of home dialysis) under the MBS(2,3).

All recommendations relating to these items are included in this report for consultation. The Committee also provided input on items that will be referred to their primary reviewing Clinical Committee to assist with their recommendations for consultation.

An inclusive set of stakeholders is now engaged in consultation on the recommendations outlined in this report. Following this period of consultation, the recommendations will be finalised and presented 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.

## 1.3 Recommendations

The Committee has highlighted its most important recommendations below. The complete recommendations (and the accompanying rationales) for all items can be found in Section 4. Recommendations developed for referral to other committees are presented in Section 5. A complete list of items, including the nature of the recommendations and the page number for each recommendation, can be found in Appendices A and B (in table summary form).

### Recommendations for consultation

The Committee's provisional recommendations for stakeholder consultation are that a new item should be created for dialysis in very remote areas, two renal dialysis items should be restructured into a single weekly item, two items should be deleted from the MBS, and one item should remain unchanged. These changes focus on increasing access to medical services, encouraging best practice and simplifying the MBS to improve patient care by (i) consolidating item numbers; (ii) improving the clarity of descriptors (with support from explanatory notes); and (iii) providing clinical guidance for appropriate use through explanatory notes. The most important recommendations are summarised below.

- △ **Very remote dialysis item.** Address the access gap by creating an item to fund the provision of dialysis in very remote areas, including nurse supervision. At present, most Indigenous patients from very remote areas are forced to relocate for dialysis services (4). The proposed item would help to address this problem by funding the ongoing costs of providing dialysis in very remote areas.
- △ **Weekly dialysis supervision item.** Create a consolidated weekly payment to replace items 13100 and 13103. This would reduce variability in the billing of items, encourage best-practice care and remove incentives to over-service patients. Consultations and supervision of dialysis in

the routine care of a patient on in-centre dialysis would be included. This item would be introduced with a provisional MBS fee and an economic review after 12 months to ensure cost neutrality.

- △ **Paediatric–adult transition.** Consider measures to better address the transition from paediatric to adult services for patients with complex kidney disease, particularly the significant allograft loss that occurs during this period. This recommendation will be considered by the Taskforce and if endorsed, the issue will be referred to an appropriate government or inter-governmental body or group, such as the Council of Australian Governments.

### Recommendations for referral to other committees

The Committee's provisional recommendations for the consideration of other Clinical Committees concern items that were assigned by the Taskforce to the Urology Clinical Committee (UCC), the Nurse Practitioner and Participating Midwife Clinical Committee (NP&PMCC), the Aboriginal and Torres Strait Islander Clinical Committee (ATSICC), the General Practice and Primary Care Clinical Committee (GPPCCC) and the Consultation Services Clinical Committee (CSCC) for primary review. The most important recommendations are summarised below.

- △ **Specialist attendances claim.** Amend the General Rules for Professional Attendances items to prevent medical practitioners from claiming specialist attendances for the supervision of dialysis. It was noted that some providers currently claim consults (item 116) in place of the dedicated dialysis supervision item (13103). This results in a lack of transparency in MBS data and is not the intent of the items. The exception is when a consultation is performed for non-routine management in consulting rooms, or when admission to hospital is required due to deterioration in a patient's condition or for non-kidney related reasons.
- △ **Nephrology nurse practitioners.** The Committee recommends that the NP&MCC consider ways to recognise and remunerate the services provided by nephrology and chronic disease nurse practitioners, particularly in rural and remote areas.
- △ **Live donor nephrectomy.** Create a new item for living donor nephrectomy to acknowledge that live donor nephrectomy is a complex operation, and to address the absence of a dedicated item for the procedure.
- △ **Renal biopsy.** Update the item descriptor to require ultrasound guidance, which reflects contemporary best practice.
- △ **Health assessments.** Recommend that the health assessment items be reviewed by the PCCC to close gaps that may result in high-risk patients being ineligible for assessments, and to ensure that all items are align with best practice.

## 1.4 Consumer Engagement

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 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.

The Committee has brought together practitioners with experience and commitment to the care of people with renal conditions and a consumer representative. This committee has examined how well

the current descriptions of Medicare items match current clinical practice to meet the need of Australians with kidney diseases.

A part of the work of the Committee has involved making the descriptions of items more accurate, so that payment data can help track the patterns of care across the country. Some items are no longer used because techniques for dialysis have changed since they were originally described and these items have been recommended to be deleted.

The Review has also given the chance to more accurately describe the complexity and time required for the care of potential kidney donors, the needs of young people moving from care in children's hospitals to adult hospitals, and the care needed for people needing health assessment. The Review has also recommended a new item to fund dialysis in very remote parts of the country which will significantly improve access to patients in these areas.

Recommendations fall into three categories with different next steps.

- △ **Recommendations to the Taskforce.** These will be considered by the Taskforce along with submissions from public consultation. The Taskforce will then 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. They 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 Government. These recommendations may take longer to be implemented as the timeline depends on the timing of the other Clinical Committees.
- △ **Recommendations beyond the MBS.** The Paediatric-adult transition recommendation is complex and reaches beyond the MBS. This will be considered by the Taskforce with any submissions from consultation and if endorsed, the Taskforce will recommend that this be considered by the appropriate body or group. This timeline is unknown, as the recipient group is unclear, however members of the Committee will work with the Department to ensure the recommendation is considered.

There is a list of all the items in plain English in Appendix D - Consumer Summary Table.



## 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 Medicare Benefits Schedule (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 an MBS Review Taskforce (the Taskforce) to review all of the 5,700 MBS items to ensure that they align with contemporary clinical evidence and practice, and to improve health outcomes for patients. The Review is clinician-led, and there are no targets for savings attached to the Review. Following stakeholder feedback, the Taskforce will present its recommendations to the Minister for Health for consideration by the Government.

#### 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-served.
- △ **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 Appropriate Use Criteria accepted by the Taskforce(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, are misused and/or pose a risk to patient safety. This step includes prioritising items as "priority 1," "priority 2" or "priority 3," using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing Working Groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the Committee, Working Groups, and relevant colleagues or colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the Review report, which provides recommendations for the Taskforce.

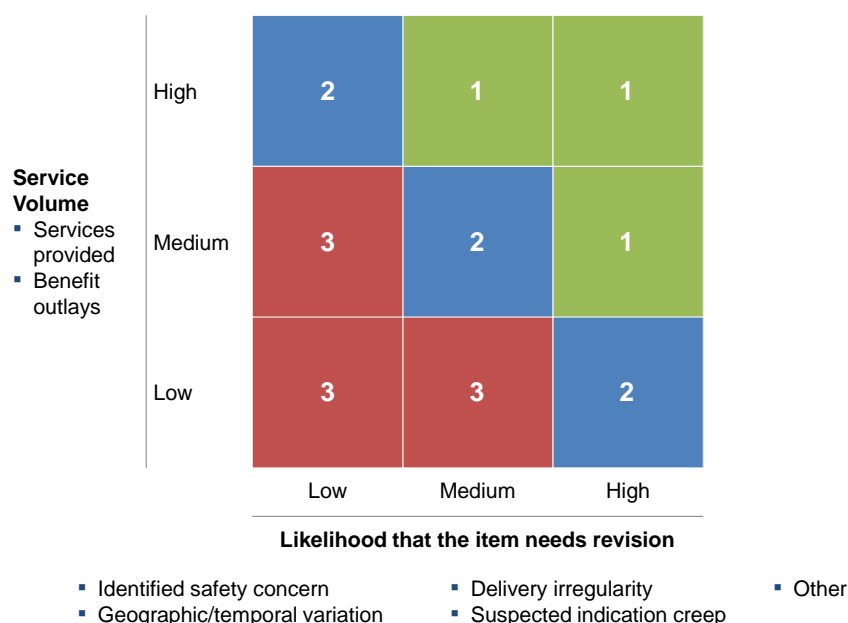
All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each Clinical Committee had to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees used a robust prioritisation methodology to 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 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 1). The Committee used this priority ranking to organise its review of item numbers and apportion the amount of time spent on each item.

**Figure 1: Prioritisation matrix**



### 3. About the Renal Clinical Committee

The Renal Clinical Committee (the Committee) is part of the second tranche of Clinical Committees. It was established in April 2016 to make recommendations to the Taskforce on MBS items within its remit, based on rapid evidence review and clinical expertise. The Taskforce asked the Committee to review renal-related MBS items.

The Committee consists of 16 members, whose 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. Committee members**

Name	Position/Organisation	Declared conflict of interest
Professor Alan Cass (Chair)	Director, Menzies School of Health Research Director, Top End Area Health Services President, ANZ Society of Nephrology	None

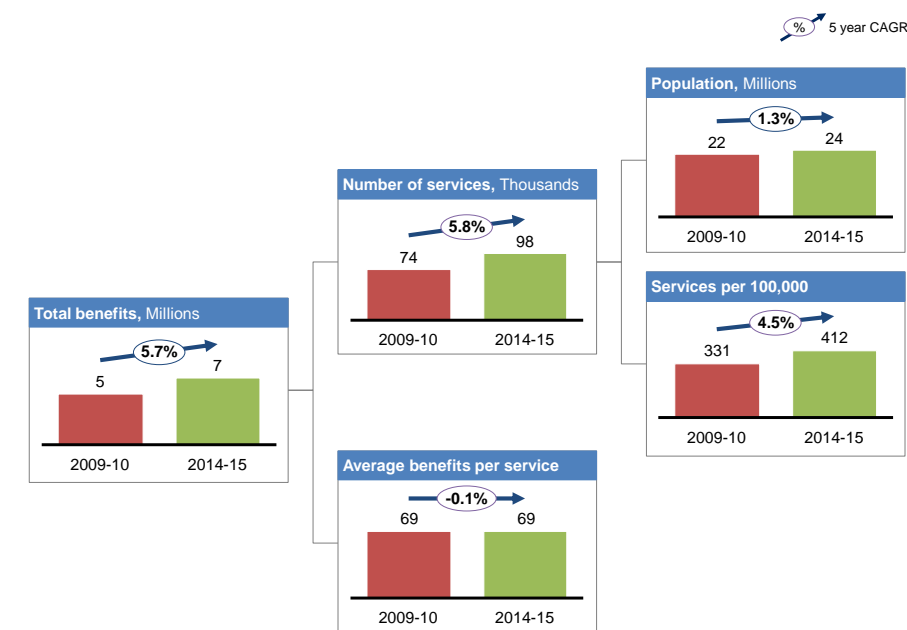
Name	Position/Organisation	Declared conflict of interest
Dr Neil Boudville	Sir Charles Gairdner Hospital and University of Western Australia	None
Associate Professor Martin Gallagher	Head, Renal Department, Concord Repatriation & General Hospital Professor of Medicine, Concord Hospital Clinical School (Sydney Medical School) Senior Director, Renal and Metabolic Division, The George Institute	None
Professor Kirsten Howard	Professor of Health Economics, School of Public Health, University of Sydney	None
Professor Matthew Jose	Renal physician, The Royal Hobart Hospital Professor of Medicine, School of Medicine, The University of Tasmania Adjunct Professor, The Menzies Institute for Medical Research	None
Dr Troy Kay	Renal physician, John Flynn Private Hospital, private practice	None
Professor Peter Kerr	Director of Nephrology, Monash Medical Centre	None
Professor Robyn Langham	Director of Nephrology, St Vincent's Hospital, Melbourne Professor of Medicine, Monash University Secretary-General, International Society of Nephrology	None
Ms Alison Marcus	Registered nurse Consumer representative	None
Professor Stephen McDonald	Director of Dialysis & Senior Staff Nephrologist, The Central Northern Renal and Transplantation Service, The Royal Adelaide Hospital Clinical Director, Renal Services, Country Health Region, SA Health Executive Officer, Australia and New Zealand Dialysis and Transplant Registry Clinical Professor, The University of Adelaide	None
Dr Amanda Robertson	Director of Nephrology Surgery, Royal Melbourne Hospital	None
Ms Lesley Salem	Nephrology and chronic disease nurse practitioner	None
Dr Paul Snelling	Renal physician, Royal Prince Alfred Hospital	None
Professor Tim Usherwood	Professor, General Practice, Westmead Clinical School, The University of Sydney	None
Dr Amanda Walker	Director, Department of Nephrology, The Royal Children's Hospital, Melbourne	None
Professor Paul Glasziou (Taskforce Ex-Officio)	Professor of Evidence-Based Medicine, Bond University	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 Areas of responsibility of the Committee

The Committee was assigned seven MBS items to review. A complete list of these items can be found in Appendix A. The seven assigned items cover procedures and services related to renal medicine. In the 2014/15 financial year (FY), these items accounted for approximately 98,000 services and \$7 million in benefits. Over the past five years, service volumes for these items have grown at 5.8 per cent per year, and the cost of benefits has increased by 5.7 per cent per year. This growth is largely explained by an increase in the number of services per capita (Figure 2). Dialysis supervision items 13100 and 13103 account for 80 per cent of total services (Figure 3).

Figure 2: Drivers of growth



SOURCE: MBS COGNOS data

Figure 3: Renal items by service volume

Assigned items – Grouped items by total number of services (2014-15)		% of total services	Services 5-year CAGR	Benefits (2014-15) \$ Millions
Supervision Dialysis <45 mins (13103)	77,200	79%	8.1%	4.16
Management Home Dialysis (13104)	19,018	19%	0.9%	2.39
Supervision Dialysis >45 mins (13100)	1,049	1%	-18.6%	0.11
Insertion Peritoneal Catheter (13109)	410	0%	4.7%	0.07
Removal Peritoneal Catheter (13110)	178	0%	3.3%	0.03
Declotting arteriovenous shunt (13106)	6	0%	8.4%	0.00
Peritoneal insertion by abdominal puncture (13112)	3	0%	-38.8%	0.00

SOURCE: MBS COGNOS data

### 3.3 Summary of the Committee's review approach

The Committee completed a review of its seven items across five meetings, during which it developed the recommendations and rationales outlined in Section 4. Recommendations were also developed for referral to other committees. These are outlined in Section 5.

The Review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional provider and patient-level data, when required. The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were sourced from medical journals (such as the *BMJ*) and other sources, such as the Central Australian Renal Study and KHA-CARI Renal Guidelines.

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.

## 4. Recommendations for consultation

### Introduction

The Committee reviewed seven assigned renal items and made recommendations based on evidence and clinical expertise, in consultation with relevant stakeholders. The Committee's most important provisional recommendations for stakeholder consultation are as follows: (i) a new item should be created for dialysis services in very remote areas; (ii) two fee-for-service items should be restructured into a single weekly item; (iii) two items should be deleted from the MBS; and (iv) one item should remain unchanged. The changes focus on increasing access to medical services, encouraging best practice and simplifying the MBS to improve patient care.

The Committee's assigned seven items all related to the initiation and supervision of haemodialysis and peritoneal dialysis. In 2014/15 these items combined provided for 97,864 services and \$6.8 million in benefits. The average growth in services is 5.8 per cent per year, though item 13103 for supervision of dialysis accounts for 78 per cent of services and is growing at 8.1 per cent per year. There were 12,000 patients on dialysis in Australia in 2014/15, of which approximately 4,400 received dialysis supervision services under the MBS. There are an estimated 3,600 patients currently receiving home dialysis of which, 73 per cent (n=2,663) claimed supervision (item 13104 planning and management of home dialysis) under the MBS(2,3).

The recommendations are organised by item type, with higher priority groups presented first.

### 4.1 Very remote dialysis item

#### Recommendation

- △ Create a new MBS item to fund the provision of dialysis in very remote areas by nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers. The proposed descriptor would contain the following elements:
- Management of haemo-dialysis, for each service provided to a person with end-stage kidney disease by or on behalf of a medical practitioner, who is employed by or contracted to a primary care organisation that provides haemodialysis services;
  - The service is administered by a renal nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker with appropriate training to support dialysis patients under the auspices of a medical practitioner; and
  - The patient is not an admitted patient of a hospital; and
  - The community facility for delivering the service is in a very remote area, defined by Modified Monash Model 7; and
  - The service is provided by a:
    - Local primary care clinic or NGO; or
    - By a health organisation with the support of the local primary care clinic; and
  - The person administering the dialysis is employed by or contracted to the service described above; and
  - The patient is under the care of a nephrologist affiliated with the local regional dialysis service, with review every 3–6 months:
    - Physically, or

- Via telehealth if the patient is located:
  - Within a telehealth eligible area; and
  - At the time of attendance at least 15 kms by road from the specialist.

△ The proposed explanatory notes for this new item are as follows:

- Primary Care Clinic refers to the first point of health care, usually provided in remote areas by nursing, health practitioner and health worker staff in community health clinics, including government, non-government and Aboriginal Community Controlled Health Services.
- Adequate training will be satisfied where the health care provider, such as a nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker, complies with state/territory requirements for the safe administration of dialysis in that role.

## Rationale

The recommendation focuses on improving access to care, and is based on the following observations.

- △ Kidney disease is a significant and serious health issue that is considered a disease of disadvantage (5–7). In Australia, there is a steep gradient in the burden of kidney disease from urban to remote areas, with people in remote and very remote areas suffering much higher levels of disease (8). Indigenous people are also more likely to be affected, and those in remote and very remote areas have the highest rates of kidney disease (9). States and territories with large very remote areas have significant Indigenous populations living in those areas (Table 2). For instance, according to Australian Bureau of Statistics (ABS) data, 58 per cent of the Indigenous population in the Northern Territory and 32 per cent of the Indigenous population in Western Australia reside in very remote areas (Table 2) (10).

**Table 2: Indigenous population and remoteness by state (ABS data, June 2011)**

State	Indigenous	Total population	% population who are Indigenous	People living very remotely	% of people living very remotely who are Indigenous	People living very remotely who are Indigenous (n)	% Indigenous population in very remote areas
NT	68,850	231,292	30%	53,469	75%	40,102	58%
WA	88,270	2,353,409	4%	63,042	32%	20,173	23%
SA	37,408	1,639,614	2%	14,816	33%	4,889	13%
QLD	188,954	4,476,778	4%	58,365	39%	22,762	12%

- △ Access to dialysis services is limited in very remote areas, which means that the majority of people must relocate to urban areas for treatment. The financial impacts of relocation on the patient, family and health service are currently unquantified (11), but it has undeniable social, economic and health consequences (12–17). For example, individuals may become dislocated from their family, community and support networks, and social consequences such as these have been identified as the second most important cause of death for Indigenous people on dialysis (24 per cent), after cardiac events (37 per cent) (18). Relocation can also be costly, and it can result in individuals losing their jobs and their housing. As a result of these social and economic costs, relocated patients often miss treatments, which has a negative impact on health outcomes. The permanent relocation of large numbers of people (and their families) for dialysis also has significant indirect impacts on other government services, including housing,



social support services and education. These are often not considered in cost-effectiveness studies (19–22).

- △ The direct costs of providing a staffed dialysis service in a very remote location are likely to be more expensive than in an urban location, as accessible infrastructure—including transport systems and essential services, larger patient numbers and collocation of services—provide economies of scale. However, the Committee noted that studies to date have not considered the broader impact of relocating for treatment, as described above. As requirements for dialysis can extend over many years, it makes sense to provide services where people live, have support and can continue to contribute to their communities. The Committee also noted that emerging data (22) and anecdotal evidence suggest that facilities in regional and remote areas, which provide more accessible services, have better attendance rates and may improve health outcomes.
- △ The Committee agreed that appropriately trained health care providers—including renal nurses, dialysis technicians, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers — should be allowed to administer dialysis to patients. This conclusion reflects two key considerations. Firstly, the Committee noted that nurses already administer dialysis to patients in hospital. Nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers have also successfully administered and supervised dialysis patients in remote dialysis programs, such as those supported by the Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation. Secondly, the Committee noted that Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers and nurses are more readily available in remote areas, and that these providers are integral to creating a successful and sustainable workforce model. The descriptor recommends the broad term ‘health care provider,’ as the Committee noted that there have recently been regulatory changes to terms used to refer to Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers. This broad term also reflects the intent of this item, which is to allow appropriately trained health care providers to safely administer dialysis services in very remote areas. The Committee refers to nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers in this recommendation because these terms represent the current health workforce in very remote areas.
- △ Nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers do not have MBS provider numbers and cannot bill the MBS, and this item will therefore have to be claimed by a medical practitioner. However, the Committee agreed that should nurse practitioners be able to practise independently and without the direct engagement of a medical practitioner in the future, the item should be amended to allow claiming by nurse practitioners. This will ensure that clinics that transition to a nurse practitioner-supported model are able to continue providing access to dialysis services. The Committee noted that this would remain an administrative claim, with care provided by the renal-trained health care practitioner, with supervision from the local regional dialysis unit.
- △ The Committee specified that the item should only be available in very remote areas, as defined by the Modified Monash Model (MMM) level 7. People in these communities are generally unable to commute for dialysis, and they experience the most disruption as a result of relocation. It has not been extended to remote areas at this time, as it was noted that these areas (such as the eastern coast of Tasmania) are often within commuting distance of regional public hospitals, which are capable of providing a dialysis service. It is also not intended to replace in-hospital dialysis for patients within reasonable commuting distance. However, the Committee did acknowledge that commuting to regional areas from a remote location is disruptive for many patients, and that some remote areas are significantly further from a regional service than others.

- △ Importantly, the Committee noted that there is a risk that introducing this service may result in current state government funding for self-care dialysis ceasing to be available. This is expressly not the intent of this item, and the Committee is strongly supportive of the ongoing funding of patients suitable for self-care dialysis. The Committee agreed that although this risk exists, the new item is warranted because the current level of access for patients in remote areas remains very limited (despite extensive work over many years to address this), and because there are many patients for whom self-care is not possible or appropriate. The Committee strongly supports the creation of the very remote item, and it believes that there will be a significant net benefit to remote Australians and the Commonwealth, resulting from improved health outcomes and an associated reduction in the economic impact of end-stage kidney disease.
- △ The Committee agreed that the item descriptor has to be flexible in order to ensure that providers can afford to operate, and to allow for the creation of health care models tailored to the needs of local communities. Accordingly, the item was designed so that (i) the renal nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker could be employed by or contracted to a primary care clinic or organisation; and (ii) the new item could be claimed by local primary care clinics, non-government providers and private health organisations, with the support of the local primary care clinic. The Committee believes that the support of the local community and local primary care clinic is essential in order to ensure that the model appropriately meets the needs of very remote communities.
- △ The Committee introduced a three- to six-month mandatory review by the local regional dialysis service in order to maintain the connection between the patient and his or her local renal unit. This ensures that holistic care is provided for the patient across the complete patient journey, including continuity of care during hospitalisation and acute episodes.
- △ The Committee agreed that the review of a patient by the local regional dialysis unit could occur physically or via a teleconsultation. This is because some very remote areas are more than 500km from a local regional dialysis unit, and the Committee felt that a teleconsultation may be appropriate if a patient is stable.
- △ The Committee recommended using the MMM as it is the latest standard, with the understanding that the Department of Human Services (DHS) and the ABS will adopt this standard over time. Although estimates in Table 2 (above) have been taken using ABS data, the Committee did not regard this as a serious issue as it noted that both the MMM and the 2011 ABS census data draw on the same Australian Standard Geography Standard – Remoteness Areas (ASGS-RA). The Committee acknowledged that retrospective data may use an alternative model, and this should be considered when attempting to forecast usage.

## 4.2 Medical supervision of dialysis items: Items 13100 and 13103

Table 3: Item introduction table for items 13100 and 13103

Item	Descriptor	Schedule fee	Services FY2014/15	Total benefits	Services average annual growth
13100	Supervision in hospital by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in one day.	\$136.65	1,049	\$107,513	-18.6%

Item	Descriptor	Schedule fee	Services FY2014/15	Total benefits	Services average annual growth
13103	Supervision in hospital by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day.	\$71.20	77,200	\$4,162,558	8.1%

## Recommendations

- △ Replace items 13100 and 13103 with new item 1310X—a consolidated item claimed weekly for care of a dialysis patient—on a 12- to 24-month trial basis, with defined objectives, a scheduled review and a sunset clause. The proposed descriptor for this item is as follows:

- Item 1310X: Supervision of private patient in a hospital or dialysis facility by a consultant renal physician, of haemodialysis/haemodiafiltration/ultrafiltration treatments occurring through the week including attendances in the dialysis unit for routine assessment of the dialysis treatment and the ongoing planning, care, and monitoring required between treatments as outlined in the explanatory notes.

A record of the services provided by the claiming provider is to be maintained in the patient's clinical notes.

Claimable only where data is contributed (with patient consent) to the Australia and New Zealand Dialysis and Transplant Registry or where the provider engages in an equivalent, documented quality oversight activity.

Claimable once per calendar week (Mon to Sun) where the majority of dialysis services that week are supervised by the claiming practitioner in a private dialysis facility.

- △ Include the following proposed explanatory notes for this item:

- Supervision and attendances refer to the routine care associated with in-centre and satellite haemodialysis/haemodiafiltration/ultrafiltration patients. Attendances for non-routine consultations in consulting suites are eligible for the professional attendances item numbers where they meet the requirements of those items.

Ongoing planning, care, and monitoring would cover:

- Provision of a monthly care plan to the patient or the patient's agent which outlines the care which will be provided to them by the claiming provider; and
- Regular discussions, at least monthly, with the patient and patient's agent regarding their satisfaction with the care they are receiving and how that experience could be improved; and
- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly); and
- Feedback of results to the patient and his or her treating general practitioner and other members of the health care team; and
- Adjustments to medications and dialysis therapies based upon these results; and
- Co-ordination of regular investigations required to keep the patient on active transplantation lists, where relevant; and
- Referral to, and communication with, other specialists involved in the care of the patient; and

- Being available to advise the patient or the patient's agent; and
- Participation by the consultant physician in patient management discussions coordinated by renal centres.

Some elements of care may be reasonably provided by another health care provider such as a nurse or nurse practitioner, however no services should be charged in addition to this item for the routine care of the dialysis patient as described above.

It is expected that the item will be claimed once per calendar week for a patient, to a maximum of 52 claims per year. The patient must be informed that they will incur a charge for this service for which a Medicare rebate will be payable.

- △ Set an appropriate fee to reflect the work involved in the clinical care of the patient, as well as the reasonable practice costs—including education and quality assurance—of an efficient, full-time dialysis service.

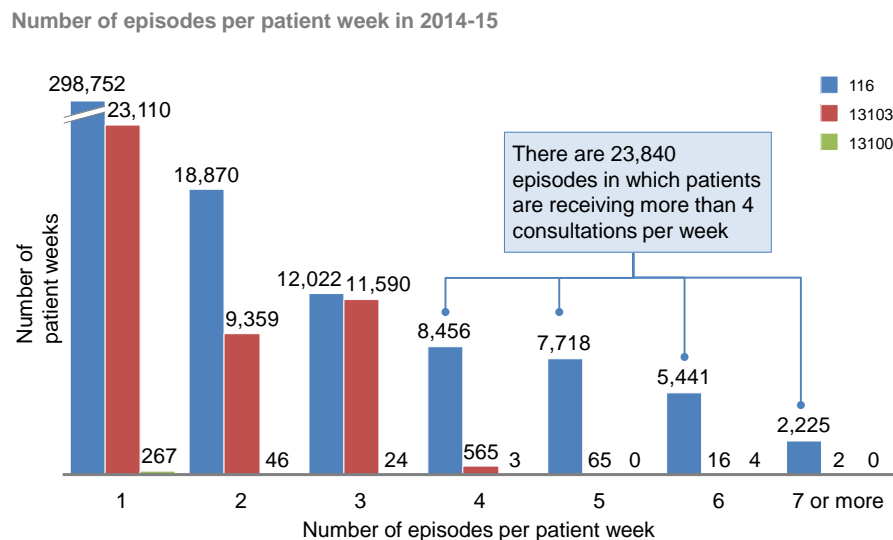
### Rationale

The recommendations focus on supporting best-practice care, and are based on the following observations.

- △ The Committee noted that the current item number only covers direct contact with a patient during a dialysis session. This does not account for the fact that much of the activity involved in caring for a dialysis patient does not require or involve direct physician–patient contact. For private dialysis patients, for example, activities such as phone calls to obtain authority prescriptions and the fortnightly recharting of medications can be time-consuming. The Committee acknowledged that many providers may be claiming item 13103 without physically attending the patient. In regional and remote clinics, for example, anecdotal evidence suggests that nurses and nurse practitioners provide services for months at a time without a medical practitioner being physically present.
- △ The Committee agreed that there is extremely wide variation in use of the current item number across physicians, which may reflect differences in clinical practice or differences in billing/claiming practices. Within the Committee, there was a lack of agreement about the appropriate frequency with which item 13103 (with the current item descriptor) could be reasonably claimed for a stable dialysis patient, with opinions ranging from every attendance for dialysis to less than once per week and only with physical attendance by the provider. The Committee agreed that the current fee-for-service model may incentivise some providers to provide more frequent dialysis services (up to six per week). Although this is not harmful to patients if the sessions are of an appropriate duration, there is no robust evidence to support this approach. MBS data showed that 4 per cent of providers claimed more than four dialysis services per patient in up to 7 per cent of patient treatment weeks. The remaining 96 per cent of providers did not claim more than four dialysis services in more than 1 per cent of patient treatment weeks (23).
- △ It was noted that the MBS data on item 13103 is also likely to provide an incomplete picture of MBS-supported dialysis, as there are providers who bill specialist attendance items (e.g., item 116) in place of item 13103 due to the higher rebate. It was agreed that it is appropriate to claim item 116 when a patient is reviewed, and a face-to-face consultation is performed and documented in line with item 116 requirements. However, the Committee felt that it is inappropriate to claim item 116 for routine dialysis supervision. Claims of item 116 can be seen in Figure 4. Co-claiming item 116 with dialysis supervision items 13100 or 13103 was also noted as a concern, although the Committee found that this occurred in less than 1 per cent of all dialysis supervision claims (23). This data may not capture all patients, however, as nephrologists who never bill renal-specific services (such as item 13013) may be classified by

the DHS as “internal medicine” and therefore may not be included. The Committee noted that there are approximately 9,500 patients dialysing in Australia, and the data obtained accounts for approximately 12.5 per cent of this population. The Committee agreed that the majority of patients are likely to have been captured in this data.

**Figure 4: Dialysis and consult claim frequency per week**



SOURCE: MBS Data (Q20321)

- △ The Committee found that service volumes for item 13100 were higher than expected. It was agreed that there was a financial incentive to claim this item, and that combining items 13100 and 13103 in a cost-neutral manner would remove this incentive without unfairly penalising providers.
- △ In light of this data and in-session discussions, the Committee agreed that the dialysis items should be re-drafted to achieve three outcomes: (i) the item(s) should reflect the ongoing care required by a dialysis patient, including between sessions; (ii) the item(s) should remove the financial incentives for specific treatment options, including in-centre versus home or community dialysis; and (iii) the item(s) should be linked to quality care or patient outcomes. The Committee also agreed that any change should be cost neutral, and should target the existing population of private patients who dialyse in the private setting.
- △ The Committee agreed that introducing an item that provides a weekly payment model could achieve the first outcome—reflect the ongoing care required by a dialysis patient—by facilitating ongoing planning, care and monitoring for patients receiving dialysis (see the proposed explanatory notes). It also agreed that the second outcome—remove financial incentives for specific treatment options—could be partially addressed through this weekly payment, which would remove the incentive to provide a specific number of services per week. However, the weekly payment model would not address the significant remuneration disparity between in-hospital and home dialysis supervision. It was noted that home peritoneal dialysis is not available for many private patients as this service requires transfer of care to a public hospital service. This is necessary to cover the non-medical supervision costs, which are not currently funded by private health insurers for home dialysis that does not require an ‘admission’ to a hospital or satellite service. It was noted that home dialysis (item 13104) currently attracts rebates of approximately \$125 per month or approximately \$1,500 per year, while in-centre dialysis (item 13103) attracts rebates of approximately \$60 per service, which, if claimed three times per week for 40 weeks in a year, equates to over \$7,200 per year (excluding payments by private health insurers for each service provided). It was noted that some in-centre patients are more acutely unwell and do have higher care needs. However,

many stable in-centre patients do not have significantly higher complexity than home dialysis patients. The 40 weeks referenced in this example represent a very conservative estimate, reflecting that patients are acutely unwell for part of the year, and that some commence or cease dialysis part way through the year. The differential would be higher for a full year.

- △ The Committee agreed that a weekly consolidated payment for care of a dialysis patient would reduce inter-provider variability and simplify the billing and administration of dialysis, particularly for patients who were being reviewed and billed three times per week and would now be covered in a single claim. Practices utilising shared care models with multiple nephrologists would be required to implement appropriate fee-sharing models. Providers who currently claim fewer than 12 services per patient per year would need to bill patients more frequently, but this would involve a streamlined weekly billing process.
- △ Although weekly billing would simplify things for many providers, it may result in increased complexity and inconvenience for some patients. This is particularly true for patients of providers who do not offer claim delegation or automatic claiming. (Automatic claiming may also increase the inconvenience for patients who receive rebates via cheque.) However, the process would be simplified for patients who are billed three times per week, assuming their practices have not already implemented a process to simplify this for patients. The Committee agreed that the care of the patient should include regular assessment of patient satisfaction, which would allow for patient experience improvements to be made.
- △ The Committee noted that for a large number of patients, dialysis supervision items were claimed infrequently. It was agreed that the vast majority of patients undergo dialysis three times per week, every week. However, MBS data revealed that over a one- to two-year period, 32 per cent of patients received only one claim for dialysis, and 69 per cent of patients received less than 12 claims. The Committee considered a number of explanations for this disparity:
  - The Committee felt that some of these patients may be accounted for by acute short-term dialysis, holiday dialysis of public patients in a private facility or other extraordinary circumstances. It was also considered that providers may be claiming item 116 instead of item 13103, although it seems unusual that a provider who routinely bills item 116 for the supervision of dialysis would periodically bill item 13103, except if he or she was unable to document in the patient's notes, which is a requirement of a professional attendance.
  - The Committee agreed that the majority of this unexpected data demonstrated that providers were claiming item 13103/13100 services infrequently, such as when they physically attended and reviewed the patient, rather than for all dialysis services the patient received. It was noted that as the items refer to a professional attendance (of up to 45 minutes for item 13103), many providers interpret this as requiring attendance for direct clinical involvement in the care of the patient—an interpretation shared by the Department of Health (the Department). However, it was noted that some providers consider attendance on a dialysis unit, or being available remotely, as fulfilling the requirements for this item.
- △ The Committee noted that introducing this weekly payment model would have a moderate economic impact on providers who are at the high and low ends of claim practices. However, it noted that reducing the variability in billing and the impact of this on both patients and providers, as well as recognising the non-face-to-face time of clinicians, were the main drivers for recommending the change. Although setting the fee for this item is not within the scope of this Review, analysis was conducted to estimate economic impacts. However, due to the marked variation in claim practices, and the Committee's view that a significant proportion of patients are billed 116 services only, the Department did not have the resources to accurately model the impact of these changes on providers. High-level estimates indicate that the impact



on the top 10 per cent of providers would be in excess of \$20,000 per year (24). Unless a significant number of patients are being billed 116 services exclusively and at a high frequency, this is likely to be an under-estimation. However, it should be noted that this change is intended to be cost neutral, and as such there would be a commensurate positive economic impact for other providers (although not necessarily the current bottom 10 per cent, as these providers may have low patient volumes and thus may be minimally affected by any changes).

- △ The Committee did consider creating an item that included all specialist consultations (such as item 116) in addition to items 13100/13103 without exception. The final recommendation, however, was that routine attendance and reviews during dialysis services should be included in the weekly payment for care of the patient, and that where a non-routine consultation occurs in consulting suites, it would be appropriate to claim a professional attendance item such as item 116. When a patient is admitted to hospital for an acute deterioration or non-kidney-related reason, the attending doctors routinely bill specialist attendance items. The Committee felt that it was impractical to require in-hospital attendances to be covered by the primary nephrologist under the consolidated item, as would be the case in a full capitation model.
- △ The Committee also considered a monthly payment model, but it felt that this would be impractical due to the issues created by the retention of 116 access for some circumstances (as described above). As it is not reasonable to double pay for the care of a patient, the monthly payment would be inappropriate for any month in which a patient had an acute inpatient admission, and for that month, the fee-for-service dialysis items would need to be billed as appropriate. Given this complexity, it was agreed that a monthly payment model was impractical, but that a weekly model would provide a reasonable balance. It was also agreed that the consolidated item should only be claimed if the majority of dialysis services in the week (usually two out of three) were provided privately by the claiming provider.
- △ With regards to the third intended outcome of drafting this item—that the item(s) should be linked to quality or outcome measures—the Committee discussed the possibility of including an incentive for care quality and outcome tracking. It was noted that international examples of capitated or episode-based payment models generally incorporate robust quality frameworks to ensure appropriate care is provided, as there is a financial incentive for providers to provide cheaper care to patients. It was noted that the current fee-for-service model of the MBS assumes that simply because a service is provided, it is of sufficient quality due to self-regulation of the profession. However, it also noted that in some cases this may not be true. The Committee discussed potential quality assurance approaches and agreed that there are currently no widely accepted markers of high-quality care, and that existing metrics are significantly affected by factors such as patient mix.
- △ The Committee agreed that patients dialysing with a central venous catheter (CVC) are more susceptible to infections, hospitalisations and increased risk of death when compared to patients with an arteriovenous (AV) fistula or graft for vascular access (25). The Committee considered whether it would be appropriate to create differentiated items based on either commencement of dialysis with long-term access in place, or based on the type of access used for each service. Regarding commencement, it was agreed that unplanned commencement often occurs in patients who have not previously seen a nephrologist, or when an acute and unexpected deterioration occurs. As such, it was agreed that differentiating the items would be unlikely to affect these patient populations. The Committee also considered a separate item for any service provided via CVC, regardless of commencement access. However, the Committee ultimately felt that this was inappropriate for several reasons. Firstly, there are situations when it would be clinically appropriate to use a CVC—for example, in an elderly patient who only requires short-term access. In such patients, a lower rebate—whether passed on to the patient through increased out-of-pocket expense or absorbed by the provider—may

create inequity in situations where appropriate patient-centred care was provided. Consideration was also given to the creation of split items without a fee differential for tracking purposes. This was not favoured, however, as it was noted that unique codes that carry equal remuneration are often not appropriately coded. Finally, it was noted that any differentiation based on access type would be very difficult to enforce. It was agreed that the majority of patients in Australia dialyse using long-term AV fistula or graft access. Any audit of providers in an attempt to identify CVC patients being claimed under the AV fistula item would require analysis of a high volume of records in order to have a reasonable probability of detecting a case if misuse had occurred. The Committee would be willing to consider the creation of differentiated items by access again, if this was felt to offer additional value to the health system.

- △ It was agreed that implementing an episode-based payment model without quality metrics presented a risk. However, the Committee felt that this risk was small due to the fragility of the patient population, who would deteriorate rapidly with inappropriate care. This risk is also significantly mitigated by the current near-universal participation of dialysis providers in the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA). ANZDATA provides quarterly haemodialysis key performance indicator reports to participating dialysis units, including metrics such as percentage starting with an AV fistula or graft, number of early referrals and percentage of early referrals with planned access. Hospital reports are also provided (which cover a rolling six-year window), and a transplant centre report summarises the outcome of transplant patients (patient and graft survival) over the six-year period. All reports compare the recipient unit or hospital to the average across Australia and New Zealand. ANZDATA also publishes public reports, including an annual report and annual dialysis and transplant hospital reports. These reports provide information on the incidence and prevalence of end-stage kidney disease, as well as the outcomes of dialysis and transplantation treatment performed in Australia and New Zealand. They contain comprehensive analysis of patient care outcomes, such as technique and patient survival, as well as trends and variations in the treatment of patients. The annual hospital reports (for dialysis and transplants) also include some of the outcomes of dialysis treatment performed in Australia and New Zealand, including a “standardised mortality ratio” for each hospital, which reflects the number of deaths over the number of “expected deaths,” based on the patient population of each hospital. The data collected by the registry is also regularly used for publications, with over 40 articles published in the last two years.
- △ Although nearly all dialysis units contribute to ANZDATA, the Committee noted that a very small number of providers elect not to participate, and that some patients at contributing units do not consent to their data being provided. For this reason, the Committee recommended that where registry data is not provided, an equivalent patient safety and quality assurance system should be instituted. Implementation of this aspect of the recommendation—including confirmation of participation, and appropriate use by the Department of the registry data to monitor quality of care by claiming providers—was not discussed. The Committee agrees that the quality of care currently provided under the MBS is already of a high standard. It is not expected that the move to a weekly payment model will have any material negative impacts on patient health outcomes or experience.
- △ The Committee discussed the broader implications of this recommendation for the MBS. It was noted that there is a risk that this item will be seen as establishing a precedent by other providers, both general practitioners (GPs) and specialists, who care for patients with complex chronic diseases. Generally, care coordination between consultations is considered part of the routine care of that patient.
- △ The Committee agreed that there was a degree of economic risk involved in implementing this weekly payment model due to a lack of data transparency, caused by providers claiming item



116 for the supervision of dialysis. The Committee therefore recommended introducing the change on a trial basis, for 12 to 24 months, with a subsequent economic evaluation. The primary end point would be decreased claim variability while remaining net cost-neutral. If the change is found to have increased or decreased dialysis funding, steps should be taken to correct this imbalance. The Committee emphasised that it is important that this change does not inadvertently reduce the funding available for private dialysis services. Consultations with some providers who practise predominately in private settings revealed that some small facilities are already at the edge of financial viability.

Secondary outcomes could be quite varied, including patient satisfaction, quality of care and provider satisfaction outcomes, and it is essential to confirm that there is no decline in patient health outcomes. The Committee noted that this could be done in partnership with an academic institution and ANZDATA in order to allow more robust research to be completed. The details of this should be discussed if this recommendation is to be implemented, noting that baseline data must be established prior to implementing the change.

### 4.3 Arteriovenous shunt: Item 13106

Table 4: Item introduction table for item 13106

Item number	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits	Services average annual growth
13106	Declotting of an arteriovenous shunt.	\$121.35	6	\$571	8.4%

#### Recommendation

- △ Delete this item from the MBS.

#### Rationale

The recommendation focuses on modernising the MBS and is based on the following observation.

- △ The Committee agreed that arteriovenous shunts are no longer part of contemporary clinical practice. This is reflected in the extremely low volume of items claimed. In FY2014/15, for example, only six services were claimed. All patients should now have venous access established, using either fistulas or grafts.

### 4.4 Insertion of temporary catheter: Item 13112

Table 5: Item introduction table for item 13112

Item number	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits	Services average annual growth
13112	Peritoneal dialysis, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation).	\$136.65	3	\$508	-38.8%

#### Recommendation

- △ Delete this item from the MBS.

#### Rationale

The recommendation focuses on modernising the MBS and is based on the following observation.

- △ The Committee unanimously agreed that item 13112 covers a procedure that no longer reflects contemporary clinical practice and has been replaced by alternative procedures, such as insertion of catheters via laparoscopy (item 13109). This is reflected in the extremely low volume of items claimed. In FY2014/15, for example, only three services were claimed.

## 4.5 Indwelling peritoneal catheter for dialysis: Items 13109 and 13110

Table 6: Item introduction table for items 13109 and 13110

Item	Descriptor	Schedule Fee	Volume of services FY2014/15	Total benefits	Services average annual growth
13109	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis insertion and fixation of.	\$227.75	410	\$70,354	4.7%
13110	Tenckhoff peritoneal dialysis catheter, removal of (including catheter cuffs).	\$228.50	178	\$30,308	3.3%

### Recommendations

- △ Change the item descriptor for item 13110 to align the descriptors of items 13109 and 13110. The proposed descriptor is as follows: “Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis, removal of (including catheter cuffs).”
- △ Review the schedule fee for both items.

### Rationale

The recommendations focus on ensuring best practice and are based on the following observations.

- △ The Committee felt that the discrepancies between the two item descriptors were unnecessary and confusing. Aligning the wording of the two item descriptors increases consistency across the MBS.
- △ The Committee agreed that the current fee attached to item 13109 (\$227.75) does not reflect the skill and time required for the insertion or removal of a Tenckhoff catheter. Removal of a Tenckhoff catheter (item 13110), for example, requires careful dissection and removal of both the catheter and the incorporated cuffs, as well as repair of the abdominal wall (19–20). The fee also does not include an assistant fee, and the Committee agreed that an assistant is required to perform these procedures safely and accurately.
- △ Although surgeons associated with renal units usually perform insertion and removal of a Tenckhoff catheter as a specialised procedure, it is performed laparoscopically in some centres. Laparoscopic insertion or repositioning of Tenckhoff catheters are new techniques and have never had an item number. Increasing the fee for insertion and removal of a Tenckhoff catheter (whether open or laparoscopic) will better reflect the time, effort and expertise required to use these new techniques. A laparoscopy item number is currently also charged by some providers for these procedures, although the Department noted that this was not appropriate.
- △ The Committee considered whether it might be more appropriate for an alternative Clinical Committee to review this item, as only one Committee member had expertise relating to the item. However, acknowledging that this item is low volume and performed by providers from a variety of specialties, it felt that it was appropriate for the Committee to retain the item within its scope. The Committee noted that nephrologists may upskill to provide this service to their communities, particularly in rural and remote areas.
- △ The Committee agreed that the current service volume is not suggestive of a significant access issue as a result of the current schedule fee.

## 4.6 Paediatric–adult transition

### Recommendations

- △ The Committee strongly recommended referring the issue of paediatric–adult transition of patients with complex kidney disease to an appropriate government or inter-governmental body or group, such as the Council of Australian Governments.
- △ The Committee proposed that an ongoing and sustainable service (or funding for a service) should be created to provide support for the care of adolescent patients with complex kidney disease. This service should:
  - Be available for patients with complex kidney disease who are between 16 and 23 years old and within six months of transitioning from paediatric to adult services.
  - Include funding to cover the cost of young adult complex care consultations, which involve history-taking, identification of the patient’s multi-disciplinary team (MDT) care needs and outcomes to be achieved by members of the care team, the execution of all tasks necessary to achieve these outcomes, and evaluation of patient progress against clear, patient-focused goals.
  - Be attended by the following: at least one nephrologist; a youth worker; at least two other providers who provide a different kind of care or service to the patient (specifically, a specialist nurse, general practitioner or allied health professional) and are not the patient’s family/carers; and the patient (who should be physically present). Additional specialists (e.g., a paediatric nephrologist or urologist) may be in attendance as appropriate.
  - Involve regular communication with and involvement of the patient’s usual GP.
  - Take place in a youth-friendly location, generally a clinic or rooms designed for young adults, separate from a hospital.
  - Provide care over a period of around two years, noting that cognitive development—particularly of executive functioning—is often somewhat delayed in complex chronic renal patients.

### Rationale

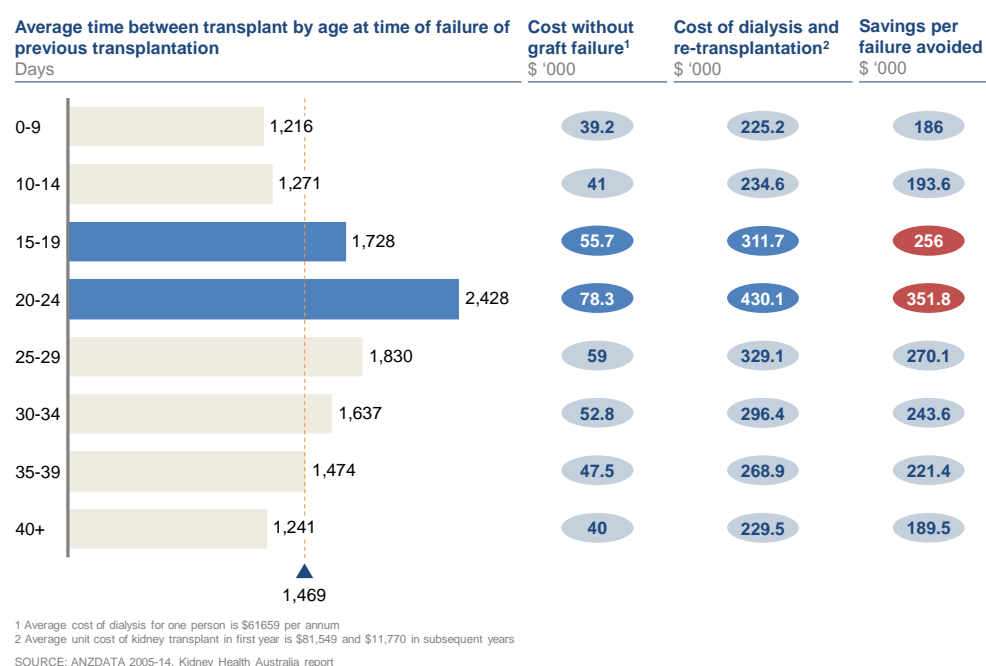
These recommendations focus on improving patient outcomes and are based on the following observations.

- △ Teenagers and young adults have poorer outcomes than other transplant recipients, including a high incidence of late acute rejection episodes. Non-adherence to immunosuppressive regimens is a key contributory factor (28), which suggests that young people have poorer compliance and often miss out on adequate follow-up. These poor outcomes reflect a number of difficulties unique to teenage and young adult patients. For example, patients are transitioning from a paediatric system, where parents and the health care team assume great responsibility, to an adult system where they need to become responsible for their own care—a shift that can require upskilling. In addition, it is difficult to coordinate care as young adults with complex health care needs transition from paediatric to adult care, which involves many new providers. It is particularly challenging for patients with congenital renal disease and genetic or rare syndromes, many of which are unfamiliar to nephrologists who care for adults.
- △ Furthermore, it can be difficult to engage teenagers and young adults in their own health care in an unfamiliar health system that is geared towards mature and older patients. This is particularly true of cognitively vulnerable young adults, who may need additional help to understand their own medical/surgical history and their health care needs. This can result in

psychological distress, anxiety, depression and poor health outcomes (29), which often lead to disengagement from health care services.

- △ Evidence suggests that introducing this service could improve outcomes for young adults with functioning renal transplants. In the United Kingdom, for example, a dedicated young adult clinic was established for patients aged 16–28 years with chronic kidney disease 4+. Among the small number of patients at this clinic (n=21), the rate of five-year graft loss fell from 67 per cent to 0 per cent during the first 10 years (30). Although the population in Australia is too small to allow for sufficiently powered sample sizes, a review of ANZDATA registry data from 1985 to 2010 showed that rates of graft loss due to late acute rejection and noncompliance were higher in young adult patients, while graft loss from other causes remained relatively flat (31). There is clinical consensus in both the Australian and international nephrology communities that this age group is at significant risk, and that steps should be taken to reduce this risk (32).
- △ The Committee agreed that ongoing case management and the involvement of primary carers is important, and that this would vary by patient context. For example, care of a regional transplant patient would require the active involvement of the patient's local supports and providers, in addition to specialist metro services. For high-risk patients, case management between visits may improve outcomes. The Committee agreed that for all patients, there should be a specific requirement to liaise with and communicate with the patient's usual GP.
- △ The proposed service could be provided at a reasonably low cost due to the small number of potential patients. There are approximately 330 patients in Australia aged 15–24 with functioning renal transplants (3), and the populations for most other serious chronic paediatric conditions are expected to be similarly low.
- △ In addition to improving patient outcomes, the proposed service will make it possible to avoid the significant costs associated with graft loss. The healthcare costs of a patient with a functioning transplant averages \$11,770 per annum, considerably lower than that of a patient on dialysis at \$61,659 per annum. As such, each year of dialysis due to failure increases healthcare costs by \$53,545p.a., with the year of transplantation costing \$81,549p.a.(33). Data from the ANZDATA registry of all transplantations from 2005 to 2014 shows that the interval between graft failure and re-transplantation in young adults is 1,700-2,400 days (Figure 5). The resulting potential economic impact for each graft failure is \$256,000-\$351,000 in healthcare expenditure. In total there have been 101 re-transplantations between 2005 and 2014 (age at time of graft failure 15-19 n=39, 20-24 n=62), with an estimated cost of \$31 million, or \$3 million per year(31).
- △ Clinicians across Australia have been searching for sustainable funding for this model for several years, and it remains an ongoing challenge. Current models (Appendix C - Current Australian paediatric–adult renal transition models) are funded through grants and charitable donations, which may not be sustainable sources. Funding from public hospital services is generally unavailable, as the services require a youth-appropriate, off-site location, and hospitals do not generally consider off-site services to fall within their responsibility. Community sector funding has not been able to support this service due to limited resources for current services in this setting, such as community mental health care. Recurrent Commonwealth funding under the MBS was discussed, but this presented several challenges. Most notably, funding for the allied health services by unregistered providers, such as youth workers, may not be effective under the MBS, where there is no line-of-sight visibility to the claiming provider. It was agreed that funding these services would provide significant economic benefits for both state and federal governments, but a clear and sustainable funding model has yet to be identified.

**Figure 5: Average time between graft failure and re-transplantation**



- △ The Committee discussed which provider generally holds overarching responsibility for the patient and the services during the adolescent years. It was acknowledged that for adolescents, the paediatric nephrologist often has additional expertise in working with younger patients, but during this period the focus is on transitioning away from paediatric services. It is imperative that rapport with adult providers and services is established during this time, and this is undermined if the paediatric providers remain the 'lead,' with services predominately occurring in the usual paediatric clinic. For this reason, the Committee agreed that overriding responsibility should rest with the adult providers.
- △ The Committee strongly supported consideration of other populations that fall between the gaps of state and Commonwealth funding, hospital and community care, and paediatric and adult services, where the significant lack of clarity in terms of accountability for funding care has negative health outcomes. Such populations would include adolescents with spina bifida, cystic fibrosis, complex urological conditions, cerebral palsy and other organ transplants. It is beyond the expertise of this Committee to recommend specific solutions for these populations, but the Taskforce should consider them when considering this issue.

## 4.7 Stakeholder impact statement

The new item for very remote dialysis is expected to address a significant access gap that currently forces very remote dialysis patients to relocate, with all the attendant individual and social costs. Adding this item is expected to have profound positive social and health outcome impacts for patients, as well as positive economic outcomes for patients, state governments and the federal Government.

The creation of a weekly dialysis supervision item is expected to redistribute funds between nephrologists, depending on current billing practices. For approximately 10 per cent of providers, billings are expected to decrease by more than \$20,000 per year (24). There are no expected impacts on patient outcomes as a result of this change. However, there may be an improvement in care coordination activities among a small subset of nephrologists, whose attention is drawn to the level of ongoing care expected. This may also improve communication with primary care clinicians.

Patients and providers are expected to benefit from the recommendations to delete or change items. Fewer and clearer item descriptors, supported by clear explanatory notes, will minimise confusion for providers and incentivise best-practice clinical care for patients.

## 5. Recommendations to other committees

### Introduction

The Committee has also developed provisional recommendations for the consideration of other committees. These recommendations concern items that were assigned by the Taskforce to the Urology Clinical Committee (UCC), the Nurse Practitioner and Participating Midwife Clinical Committee (NP&PMCC), the Aboriginal and Torres Strait Islander Clinical Committee (ATSICC), the General Practice and Primary Care Clinical Committee (GPPCCC) and the Consultation Services Clinical Committee (CSCC) for primary review. These recommendations will be submitted to the relevant committees for consideration as they formulate their own recommendations to the Taskforce. The recommendations will also be included in this Committee's final report and may be considered directly by the Taskforce.

The item-level recommendations can be found below in Sections 5.1–5.4, and a summary recommendation table can be found in Appendix D. Recommendations are grouped by Clinical Committee.

### 5.1 Recommendation to the Consultation Services Clinical Committee

#### 5.1.1 Healthy donor consults

Table 7: Item introduction table for items 132 and 133

Item	Descriptor	Schedule Fee	Volume of services FY2014/15	Total benefits	Services average annual growth
132	<p>Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a referring practitioner, and where</p> <p>a) assessment is undertaken that covers:</p> <ul style="list-style-type: none"> <li>— a comprehensive history, including psychosocial history and medication review;</li> <li>— comprehensive multi or detailed single organ system assessment;</li> <li>— the formulation of differential diagnoses; and</li> <li>— b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves:</li> <li>— an opinion on diagnosis and risk assessment</li> <li>— treatment options and decisions</li> <li>— medication recommendations</li> </ul> <p>Not being an attendance on a patient in respect of whom, an attendance under items 110, 116</p>	\$263.90	790,316	\$177,936,772	12.7%

Item	Descriptor	Schedule Fee	Volume of services FY2014/15	Total benefits	Services average annual growth
	<p>and 119 has been received on the same day by the same consultant physician.</p> <p>Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician.</p>				
133	<p>Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where:</p> <p>a) a review is undertaken that covers:</p> <ul style="list-style-type: none"> <li>— review of initial presenting problem/s and results of diagnostic investigations</li> <li>— review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment,</li> <li>— review of original and differential diagnoses; and</li> </ul> <p>b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate:</p> <ul style="list-style-type: none"> <li>— a revised opinion on the diagnosis and risk assessment</li> <li>— treatment options and decisions</li> <li>— revised medication recommendations</li> </ul> <p>Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician or locum tenens.</p> <p>Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132. Item 133 can be provided by either the same consultant physician or a locum tenens.</p> <p>Payable no more than twice in any 12 month period.</p>	\$132.10	525,184	\$59,970,098	13.7%

### Recommendation

- △ Amend the item descriptor for items 132 and 133 to include consultation with a healthy donor for transplant workup as an indication.

### Rationale

The recommendation focuses on improving quality of care, and is based on the following observations.

- △ The Committee agreed that healthy donor workups are complex consultations. They are lengthy, and they require the nephrologist to share information about the donation process,



including risks, long-term health implications, and the expected duration of admission and recovery (34). They also involve carefully managing patient vulnerability and ensuring informed patient consent (34), and decisions made during these consultations significantly affect the lives of prospective recipients and donors. (Live kidney donation has better short-term and long-term outcomes for the recipient than other treatment options, including deceased kidney donation.) (34) They also require complex estimation of long-term health risks, especially as growing rates of obesity, diabetes and associated co-morbidities increase the risk of future renal disease for the donor (35). The Committee agreed that a detailed and patient-focused approach to consent with a potential donor may increase a patient's likelihood of proceeding with donation and allow the donor to make this decision in a more informed manner.

- △ The wording of item 132 does not clearly extend to cover healthy donor workups, as it requires the patient to have at least two morbidities—a condition not met by many donors as the assumption is that the donor is healthy.
- △ The expected economic impact of this change is unlikely to be significant, both because the Committee believes that many providers may be already using item 132 for these consults, and because the volume of healthy donor transplants is less than 270 a year nationwide (36).
- △ The Committee agreed that following the initial post-transplant period, it would be appropriate for the donor to be followed up using item 116 claims.

### **5.1.2 Claiming specialist attendances**

#### **Recommendations**

- △ Amend the MBS section on General Rules for Professional Attendances to:
  - Prevent nephrologists from claiming specialist attendances for the supervision of routine dialysis.
  - Prevent nephrologists from co-claiming dialysis supervision items 13103 and 13100 with consultation items.
- △ Monitor specialist attendance claim patterns in order to identify providers with high rates of item 116 claims per patient, who may be inappropriately claiming the item. This could be achieved using the MBS compliance function.

#### **Rationale**

The recommendations focus on ensuring appropriate use, and are based on the following observations.

- △ The Committee expressed concern that some providers are claiming consultation items, particularly item 116, instead of dialysis supervision items such as item 13103. The Committee noted that a consultation is distinct from supervision of dialysis. For this reason, there is a dedicated item for supervision of dialysis, which should be claimed when dialysis is being supervised. The Committee felt that providers were claiming consultation items because they are better remunerated. Committee members also expressed concern that providers who are claiming dialysis as consultation items (such as item 116) may not be complying with the requirements for these items, such as physical consultation and documentation of the consultation in the patient's medical record. It was noted that such claims limit transparency across the MBS about the nature of services that are being provided, and that it is not possible to determine the actual number of dialysis services provided across the MBS when a portion are being claimed as miscellaneous items.

- △ The Committee agreed that although an acutely unwell dialysis patient may need frequent 116 reviews, a stable patient would generally require a 116 review every one to three months. Consistently higher claiming rates may indicate misuse of the items. Should the proposed consolidated weekly payment model (item 1310X) be implemented, this would include all routine reviews, including in consulting suites, and the creation of associated letters. However, if a patient is acutely unwell and admitted to hospital, it is reasonable not to claim the consolidated dialysis supervision item, and for provider(s) involved in the acute care episode to claim the appropriate professional attendance items.

## 5.2 Recommendations to the Nurse Practitioner and Participating Midwife Clinical Committee

### Recommendations

- △ Consider increasing access to existing items or creating appropriate items for these services to reflect the scope of services provided by nephrology nurse practitioners and chronic disease nurse practitioners providing care for patients with kidney disease. Services that are currently provided by nephrology nurse practitioners—particularly in rural and remote areas and with Aboriginal Medical Services (AMS)—include procedures, referrals, and contributions to health assessments and management plans.
- △ Consider what steps could be taken to ensure that the extent and nature of the work performed by nurse practitioners is captured by the MBS. This could be achieved through various mechanisms, some of which are described below. The Committee acknowledges that this is a complex policy space that warrants detailed discussion.
- △ Consider creating a nurse practitioner attendance item for longer consultations, such as those required for complex patients with end-stage kidney disease.

### Rationale

The recommendations focus on improving access to care and are based on the following observations.

- △ The Committee noted that nurse practitioners play an important role in the provision of care for patients with end-stage kidney disease and other chronic conditions, particularly in rural and remote areas. The Australian College of Nurse Practitioners estimates that there are over 130 nurse practitioners working in nephrology as a specialist field or providing care to nephrology patients under a chronic disease focus. More than half of these providers are practising in rural and remote areas. Many of these providers are employed by public hospitals and provide services to AMS and patients in other centres, which have an exemption from section 19(2) of the Health Insurance Act 1973. This allows the provider to bill MBS items despite receiving other government funding. It was felt that nurse practitioners provide a number of services for these patients but are not currently able to claim for these services under the MBS. Examples may include performing ECGs, referring for ultrasounds, suturing and contributing to health assessments.
- △ Any additional access to items granted to nurse practitioners would need to be within the scope of the individual provider. It was stated that many nurse practitioners are now graduating with a generalist scope, and many nephrology/chronic disease nurse practitioners are already trained in many diagnostic and procedural areas of care. Although an appropriately qualified nurse practitioner could perform some services fully, certain services (such as health assessments) are comprehensive and may not be able to be fully completed by a nurse practitioner independently. The Committee agreed that it may be reasonable to consider either an item that reflects a nurse practitioner's contribution to a GP health assessment, or an

item for nurse practitioner health assessments within the area of expertise of that practitioner. It was also noted that the Primary Care Clinical Committee will be reviewing the health assessment items, and that these reviews should occur in tandem.

- △ Distinct from claiming additional services, the Committee noted that under the current items, it is not possible to identify the services provided by nephrology nurse practitioners under the MBS. The nurse practitioner consult items are time-tiered in the same way as medical consults, but the MBS does not currently record specialty areas for nurse practitioners. As such, it is impossible to determine the extent of nephrology or other services currently being provided. The Committee discussed potential solutions for this but acknowledged that this was a complex policy discussion with implications for all nurse practitioners, not only those specialising in nephrology. Three potential solutions were discussed and are included here for consideration.
  1. Create specific duplicate items for individual specialties, with or without specific criteria for both patient eligibility and services to be provided—for example, a consult for kidney disease lasting more than 20 minutes, which includes a specified set of criteria.
  2. Create items of negligible value that identify the specialty of the provider, and have them co-claimed with any service provided.
  3. Recommend that nurse practitioners be attributed specialty designations based on their area(s) of practice.
- △ The Committee agreed that creating an item for more than 45 minutes may also be warranted, acknowledging that a consultation with a complex chronic kidney patient often takes considerable time if all appropriate aspects of care are reviewed and addressed.

## 5.3 Recommendations to the Urology Clinical Committee

### 5.3.1 *Living donor nephrectomy*

#### Recommendations

- △ Create a new MBS number for “Living donor nephrectomy, Laparoscopic and/or open,” including use of an assistant.
- △ When determining the schedule fee for the item, the MSAC should consider that item 36532 (for nephro-urectomy, for tumour) is the most equivalent service on the MBS.

#### Rationale

The recommendations focus on supporting best practice and are based on the following observations.

- △ Living donor nephrectomy is a unique operation performed to procure a kidney for transplantation. It is usually performed as a laparoscopic procedure, which is a standard procedure for live donor operations and has been widely used in Australia since 2007 (37). It is different and more complex than ablative nephrectomy for cancer or stone disease as it is very important to take the maximum length of the renal artery, vein and ureter, and to cause no damage to the kidney, in order to facilitate the transplant operation. For this reason, it is only performed by a small group of general transplant, vascular and urology surgeons who are specially trained in the procedure. Approximately 260 donor nephrectomies are performed in Australia each year (36).

- △ Donor nephrectomy, either open or laparoscopic, has never had an item number attached to it. For this reason, surgeons who perform donor nephrectomy use a variety of MBS numbers (for example, items 36516, 36531 and 30390). A dedicated item number would be helpful to clarify and adequately remunerate the operating surgeon.
- △ An assistant is required to complete a laparoscopic donor nephrectomy successfully, as three to four ports (requiring at least two pairs of hands) are essential for the procedure. For this reason, an assistant fee is also required.

### 5.3.2 Renal biopsy

**Table 8: Item introduction table for item 36561**

Item	Descriptor	Schedule Fee	Volume of services FY2014/15	Total benefits	Services average annual growth
36561	Renal Biopsy (closed). (Anaes.)	\$172.50	1,592	\$220,437	10.1%

#### Recommendation

- △ Amend the descriptor for item 36561 to include a requirement that practitioners use ultrasound guidance when undertaking a renal biopsy. The proposed descriptor is as follows: “Renal biopsy (closed) performed with ultrasound guidance.”

#### Rationale

The recommendation focuses on ensuring best practice and is based on the following observations.

- △ Percutaneous renal biopsy continues to play an essential role in characterising and defining the processes involved in chronic and acute kidney disease. Although there are no global guidelines that outline when to perform a diagnostic renal biopsy, it remains an important diagnostic, prognostic and relatively safe test. Figures indicate that there are relatively few procedures undertaken in the private setting under the MBS, but there is a clear indication for its ongoing schedule. Although the procedure has historically centred on diagnosing parenchymal renal disorders, the procedure has also found increased utility in the diagnosis and subsequent management of small renal tumours. There are no guidelines on the utility of renal tumour biopsy, but it is recognised that biopsy of small renal tumours has a high diagnostic yield and low risk of complications.
- △ The Committee agreed that current best practice for renal biopsy involves the use of ultrasound (38), and that biopsy without ultrasound guidance should no longer be performed. The Committee felt that clinical practice had already shifted to reflect this. Services are provided under CT guidance, although there are specific items for deep organ biopsy under CT guidance.
- △ The Committee noted that when a nephrologist who has not been accredited under the Diagnostic Imaging Services Table (DIST) performs a renal biopsy, only item 36561 is claimable, and the ultrasound equipment may be sourced from areas equipped with them, such as an intensive care unit. However, when performed by an accredited provider, items 36561 and 55054 are claimable, as long as the provider complies with the formal reporting requirements under the DIST. Procedures performed by a radiologist, or in a radiology department with the assistance of another provider, attract a higher rebate for the same service. The Committee discussed creating a complete medical service, which would include imaging, but there was concern that the restriction on co-claiming of imaging may result in restricted access to ultrasound equipment or increased out-of-pocket costs for patients.

- △ The Committee discussed the potential for a fee review to account for the shift in practice to require ultrasound guidance. It was noted that the MSAC recently considered an application to remunerate point-of-care ultrasound guidance for other procedures, and that this application was rejected on the grounds that the guidance allows for faster and more efficient procedures, which offsets the additional cost. The Committee regarded this as a materially similar situation and determined that it was not worthwhile pursuing it.
- △ In Australia, renal biopsy using real-time ultrasound guidance is generally undertaken on the conscious patient using local anaesthetic. However, for the paediatric patient and some adult patients, general anaesthetic is required and this access should be retained.

## 5.4 Recommendations to the Aboriginal and Torres Strait Islander and General Practice and Primary Care Clinical Committees

### Recommendations

- △ Review health assessment items 701, 703, 705, 707 and 715 in relation to both eligibility and content.
- △ Incorporate an integrated health assessment MBS item for vascular disease, diabetes and kidney disease, with eligibility and content that reflect evidence-based guidelines such as those contained in the Royal Australian College of General Practitioners' (RACGP) Guidelines for Preventive Activities in General Practice.

### Rationale

The recommendations focus on improving quality of care and are based on the following observations.

- △ The range of eligible population groups and the specific requirements of the current MBS health assessment items are not fit for purpose. For example, there are many individuals with one or more of the recognised risk factors for vascular and kidney disease who are not eligible for any of the health assessment items.
- △ The specific requirements for items 701, 703, 705, 707 and 715 do not reflect current evidence-based practice and in some instances deviate significantly from this. For example, Table 9 compares the renal-related requirements with the recommendations from the RACGP's 2012 Australian Guidelines for Preventive Activities in General Practice (Edition 8). These guidelines provide explicitly evidence-based recommendations for health promotion and disease prevention in Australian general practice, categorised by sex, age and population group. They are revised every two to four years, and a new edition is currently in preparation. The only reference to such guidelines appears in the health assessment for patients aged 40–49 at high risk of type 2 diabetes.
- △ The two recommendations made by the Committee are consistent with recommendations made by other bodies. In 2015, for example, the Standing Committee on Health's Inquiry into Chronic Disease Prevention and Management in Primary Health Care recommended "that the Australian Government examine the inclusion of an integrated health assessment check for cardiovascular, kidney disease risk and diabetes as per that developed by the National Vascular Disease Prevention Alliance, where a patient does not already qualify for an existing assessment and the treating practitioner suspects they are at risk of these chronic diseases."

**Table 9: A comparison table of items 701, 703, 705 and 707 and the relevant clinical guidelines**

<b>Item/eligibility</b>	<b>Renal-related requirements stated in Associated Notes</b>	<b>Red Book (Edition 8) recommendations ACR = Urinary albumin creatinine ratio eGFR = Estimated glomerular filtration rate CKD = Chronic kidney disease</b>
701, 703, 705, 707:		
Aged 40–49 at high risk of type 2 diabetes ( <i>every 3 years</i> )	"History... physical examinations and clinical investigations in accordance with relevant guidelines"	Blood pressure, ACR and eGFR every 1–2 years
Aged 45–49 at risk of a chronic disease ( <i>once only</i> )	Clinical judgement	Blood pressure, ACR and eGFR every 1–2 years
Aged 75 and older ( <i>annually</i> )	Blood pressure measurement	Blood pressure; ACR and eGFR if at increased risk of CKD
Permanent resident of Residential Aged Care Facility ( <i>annually</i> )	Clinical judgement	Blood pressure; ACR and eGFR if at increased risk of CKD
Intellectual disability ( <i>annually</i> )	"Comprehensively assess ... physical, psychological and social function" No specific mention of CKD or vascular screening	Not specified
Humanitarian entrants ( <i>once only</i> )	Clinical judgement	Not specified
Former serving members of ADF ( <i>once only</i> )	Blood pressure	Not specified
715		
Aboriginal and Torres Strait Islander Peoples Health Assessment ( <i>annually</i> )	Blood pressure (aged 15 yrs and older); "Urinalysis (by dipstick) for proteinuria" (aged 15–54 yrs); no requirement for eGFR	Blood pressure, ACR and eGFR from 30 years of age (NB. Dipstick urinalysis <u>not</u> recommended)

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## Appendix A - Assigned items: recommendations list

Item	Current descriptor	Recommendation	Page reference
13100	Supervision of dialysis by specialist, more than 45 minutes.	Change	18
13103	Supervision of dialysis by specialist, less than 45 minutes.	Change	19
13104	Planning and management of home dialysis.	No Change	
13106	Declotting of arteriovenous shunt.	Delete	25
13109	Indwelling peritoneal catheter for dialysis insertion and fixation of. (Anaes.)	Change	26
13110	Tenckhoff peritoneal dialysis catheter, removal of. (Anaes.)	Change	26
13112	Peritoneal dialysis by abdominal puncture and insertion of temporary catheter (including associated consultation). (Anaes.)	Delete	25

## Appendix B - Additional items: recommendations list

Item	Descriptor	Recommendation	Page reference
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner – initial attendance in a single course of treatment.	Change	31
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a medical practitioner — each attendance (not being a service to which item 119 applies) subsequent to the first in a single course of treatment.	Change	31
132	Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a referring practitioner, and where a) assessment is undertaken that covers: a comprehensive history, including psychosocial history and medication review; comprehensive multi or detailed single organ system assessment; the formulation of differential diagnoses; and b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: an opinion on diagnosis and risk assessment, treatment options and decisions, medication recommendations; not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician.	Referred	31
133	Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where a) a review is undertaken that covers: – review of initial presenting problem/s and results of diagnostic investigations, – review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment, – review of original and differential diagnoses; and b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: – a revised opinion on the diagnosis and risk assessment, – treatment options and decisions, – revised medication recommendations, not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician or locum tenens. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132. Item 133 can be provided by either the same consultant physician or a locum tenens. Payable no more than twice in any 12 month period.	Referred	32

Item	Descriptor	Recommendation	Page reference
701	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information.	Referred	40
703	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient.	Referred	40
705	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient.	Referred	40
707	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient.	Referred	40
715	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent – not more than once in a 9 month period.	Referred	40
30390	Laparoscopy, diagnostic, not being a service associated with any other laparoscopic procedure, on a person 10 years of age or over. (Anaes.)	Referred	36
36516	Nephrectomy, complete. (Anaes.) (Assist.)	Referred	36
36531	Nephroureterectomy, complete, including associated bladder repair and any associated endoscopic procedure. (Anaes.) (Assist.)	Referred	36

## Appendix C - Current Australian paediatric–adult renal transition models

Best practice

Health Service	Hospital wide transition service?	Defined renal transition program	Personnel	Destination	Allied health attendance	Comments
1	Yes	Yes	Combined clinic with paed and adult nephrologists initially at children's hospital	Standard adult nephrology outpatients		Transition team provide follow up over several years
2	Yes	Yes	6 monthly transition meetings, both paed & adult nephrologists at adult hospital.	Standard adult nephrology outpatients	Allied health, and pharmacy	Youth worker not currently available as not funded
3	Yes	Yes	Out of hospital clinic with adult and paed nephrologist	Out of hospital Young adults clinic	Youth worker	Lots of peer support, works very well
4	No	Informal/ individualised	Sees adult nephrologist is adult hospital then paediatric review	Standard adult nephrology outpatients	No	Care team available in other areas but renal unfunded
5	No	Informal/ individualised	Transfer directly to adult nephrologist	Privatised clinic/ standard outpatients	No	Attempting to set up young adult clinic for over a year
6	No	Informal/ individualised	Transfer directly to adult nephrologist within same hospital	Privatised clinic	Yes	
7	Yes	Yes	Combined clinic with Paed and adult nephrologists initially at children's hospital then same at adult hospital	Unfunded young adult clinic then 1x children's hospital review then standard adult outpatients	Adult and paed nurse coordinators, SW +/- pharmacy—mostly unfunded	Needs youth worker, some peer support available

SOURCE: Paediatric specialist associated with each renal medical service

## Appendix D - Summary for consumers

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

### Recommendation 1: Very remote dialysis

Item	What it does	Committee recommendation	What would be different	Why
New item – very remote dialysis	The new item will provide funding for the delivery of dialysis by nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers in very remote areas of Australia. Dialysis is the process of removing waste products and excess fluid from the body. Dialysis is necessary when the kidneys are not able to adequately filter the blood	Introduce a new MBS item (see section 4.1 of full report for detail)	At present, most Indigenous patients from very remote areas are forced to move to more urban areas for dialysis services. This has large economic and social impacts on the patient, family and health services. The proposed new MBS item would help to address this problem by funding the delivery of dialysis in communities in very remote areas.	Having dialysis funding available for services in very remote areas will provide greater access for those patients, leading to better attendance for dialysis and improved health outcomes.

### Recommendation 2: Medical supervision of dialysis items

Item	What it does	Committee recommendation	What would be different	Why
Replace items 13100 13103 New item – single item claimable weekly for payment for care of a dialysis patient including all routine consultations	Current MBS funding is for a doctor reviewing a patient during a dialysis session.	Change the funding of in-centre dialysis supervision to better reflect the role of the nephrologist in overseeing treatment and planning of care for patients on dialysis. The new item would cover supervision of dialysis treatments occurring through the week including consultations and attendances for routine assessment of the dialysis treatment and the ongoing planning, care, and monitoring required between treatments.	The MBS benefit would be based on a week's worth of dialysis treatment including all the other care provided by the nephrologist. This means that all in-centre dialysis patients should receive the same rebate for their care.  Episodes of acute care or weeks which require a high number of specialist consultations could still be claimed separately under existing consult items instead of using the weekly dialysis item.	While most providers bill the current items less than once a month, some providers bill for every dialysis session (~3 per week). This change would ensure that all patients receive the same rebate for their dialysis supervision.  The current item numbers only describe the care that occurs during direct contact with a patient during a dialysis session. This does not account for the fact that much of the activity involved in caring for a dialysis patient does not require or involve direct physician contact during a dialysis session. Doctors are believed to already be providing this care, the new item simply recognises this.

**Recommendation 3: Arteriovenous shunt item 13106**

Item	What it does	Committee recommendation	What would be different	Why
Remove item 13106 — Declotting of an arteriovenous shunt.	Shunts were previously used as a way to access a patient's veins for dialysis. This was done using a plastic tube which would occasionally block with a blood clot and need to be cleaned out or 'declotted'.	Remove this item from the MBS.	The MBS will be simpler.  No impact on patients as shunts are no longer used and all patients should have venous access established using either fistulas or grafts.	Arteriovenous shunts are no longer part of contemporary clinical practice. This is reflected in the extremely low volume of items claimed which are believed to be miscoding.

**Recommendation 4: Insertion of temporary catheter item 13112**

Item	What it does	Committee recommendation	What would be different	Why
Remove item 13112 — Insertion of a temporary catheter	Establishing peritoneal dialysis by abdominal puncture and insertion of a temporary catheter.	Remove this item from the MBS.	No impact on patients. This procedure has been replaced in clinical practice by alternative procedures, such as insertion of catheters via laparoscopy (item 13109).	Item 13112 covers a procedure that is no longer part of contemporary clinical practice. This is reflected in the extremely low volume of items claimed.

**Recommendation 5: Indwelling peritoneal catheter for dialysis items 13109 and 13110**

Item	What it does	Committee recommendation	What would be different	Why
13109 and 13110	Peritoneal dialysis works by having a soft tube (catheter) placed in the belly by surgery. A sterile fluid is put into the belly through this catheter to absorb different chemicals and toxins the kidneys would normally filter into urine. After the filtering process is finished, the fluid leaves the body through the catheter.  These two MBS items describe the insertion (13109) and removal (13110) of an indwelling peritoneal catheter.	Change the item descriptor for item 13110 to look similar to item 13109. Both are very similar already, very minor changes made.	These descriptions will now be the same, with the only difference being whether it is for insertion and fixation, or removal of the catheter.	The discrepancies between the two item descriptors were unnecessary and confusing. Aligning the wording of the two item descriptors increases consistency across the MBS.



**Recommendation 6: Paediatric–adult transition**

<b>Item</b>	<b>What it does</b>	<b>Committee recommendation</b>	<b>What would be different</b>	<b>Why</b>
Not an MBS item Funding of services to support the care of patients during the transition from paediatric to adult services, particularly for adolescent patients with complex kidney disease.	Better co-ordinated support for adolescents and young adults, who have poorer outcomes than other transplant recipients, including a high incidence of the transplant (graft) being rejected (late acute rejection episodes).	<p>An ongoing and sustainable service (or funding for a service) should be created to provide support for the care of adolescent patients with complex kidney disease.</p> <p>As this issue involves both public and private systems; both primary and acute care; and the involvement of non-medical healthcare providers such as youth workers, the Committee recommended that the issue of paediatric–adult transition of patients with complex kidney disease be referred to an appropriate government or inter-governmental body or group, such as the Council of Australian Governments, to be addressed in an appropriate and sustainable way.</p>	Current models are funded through grants and charitable donations, which may not be sustainable and result in variable services being available across Australia. Clinicians across Australia have been searching for sustainable funding for this model for several years, and it remains an ongoing challenge.	Patients are transitioning from a paediatric system, where parents and the health care team assume great responsibility, to an adult system where they need to become responsible for their own care—a shift that can require upskilling. They also move from a youth friendly environment to an adult and often elderly focused environment, and experience the other challenges of adolescence. This leads to them disengaging and developing negative health outcomes like hospital admissions and loss of transplants. In the UK a dedicated service has been shown to prevent transplant failures which is beneficial for patients and may save \$250,000 - \$350,000 for each avoided failure.

## Appendix E - Glossary

Term	Description
ABS	Australian Bureau of Statistics
AMS	Aboriginal Medical Services
ANZDATA	Australia and New Zealand Dialysis and Transplant Registry
ATSICC	Aboriginal and Torres Strait Islander Clinical Committee
AV	Arteriovenous
CAGR	Compound annual growth rate, or the average annual growth rate over a specified time period.
Change	When referring to an item, 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 (e.g., splitting the current services provided across two or more items).
CKD	Chronic kidney disease
CVC	Central venous catheter
Department, The	Australian Government Department of Health
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
DHS	Australian Government Department of Human Services
FY	Financial year
DIST	Diagnostic Imaging Services Table
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.
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.
MDT	Multi-disciplinary 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.
Multiple operation rule	A rule governing the amount of Medicare benefit payable for multiple operations performed on a patient on the one occasion. In general, the fees for two or more operations are calculated by the following rule: <ul style="list-style-type: none"> <li>– 100 per cent for the item with the greatest schedule fee.</li> <li>– Plus 50 per cent for the item with the next greatest schedule fee.</li> <li>– Plus 25 per cent for each other item.</li> </ul>
Modified Monash Model (MMM)	A geographical classification system using up-to-date population data.

Term	Description
MSAC	Medical Services Advisory Committee
No change or 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 (e.g., references to other items, which may have changed as a result of the MBS Review or prior reviews).
NP&PMCC	Nurse Practitioner and Participating Midwife Clinical Committee
Obsolete services	Services that should no longer be provided as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
PBS	Pharmaceutical Benefits Scheme
GPPCCC	General Practice and Primary Care Clinical Committee
RACGP	Royal Australian College of General Practitioners
CSCC	Consultation Services Clinical Committee
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).
The Committee	The Renal Clinical Committee
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.
UCC	Urology Clinical Committee