
**Medicare Benefits Schedule Review
Taskforce**

**Final report from the
Ear Nose and Throat (ENT) Surgery
Clinical Committee - Tonsillectomy,
Adenoidectomy & Insertion of
Grommets**

2016

Important note

The recommendations from the Ear Nose and Throat Clinical Committee detailed in the body of this report, including the executive summary, were released for public consultation on 9 September 2016.

The Ear Nose and Throat Clinical Committee considered feedback from the public consultation and agreed that no change to its recommendations were required, however it did make changes to the item descriptor for stroboscopy which is detailed in the addendum to this report.

The final recommendations from the Ear Nose and Throat Clinical Committee and feedback from the public consultation will be provided to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for consideration before the Taskforce makes its final recommendations to Government.

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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 The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.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 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 consideration by Government.

The Ear, Nose and Throat (ENT) Surgery Clinical Committee (the Committee) was established in 2015 to undertake a review of relevant MBS items. Phase one of this review relied upon the clinical expertise of the members who sought advice from colleagues as necessary, as well as independent, targeted rapid evidence reviews of certain services.

1.1 Areas of responsibility of the Ear, Nose and Throat Surgery Clinical Committee

The Taskforce identified 196 MBS items for review by the Committee (see Appendix A for full descriptions).

- △ Otolaryngology and Audiology Diagnostic Procedures
 - 11300 to 11339 (16 items)
- △ General Surgery Items

- 30244 to 30259 (9 items) – procedures on the styloid process, parotid gland and associated structures, submandibular gland and associated structures
- 30265 to 30294 (12 items) – procedures on the salivary glands, tongue, intraoral tumours, branchial cysts and cervical esphagostomy
- 31400 to 31412 (5 items) – removal of tumours of the upper aerodigestive tract

△ Ear Nose and Throat Procedures

- 41500-41816, 41822, 41825, 41834- 41886, 41904, 41907, 41910 (145 items)

△ Audiology

- 82300 to 82332 (9 items) – services by audiologists on request from ENT specialists

Phase one of the review prioritised the items relating to tonsillectomy, adenoidectomy, insertion of grommets and identification of obsolete items. The remaining items are likely to be reviewed during phase two of the ENT review.

1.2 Items referred to other Clinical Committees for review

Gastroenterologists are the main providers of items 41819 to 41820 and 41828 to 41832 for dilatation of stricture of upper gastro-intestinal tract and balloon dilatation of oesophagus (5 items). Therefore, these items were referred to the Gastroenterology Clinical Committee for review.

Thoracic medicine physicians are the main providers of items 41889 to 41898 and item 41905 for bronchoscopy (5 items). These items were referred to the Thoracic Medicine Clinical Committee for review.

1.3 Key recommendations

Recommendation 1: Adenoidectomy

The Committee recommended changes to items for adenoidectomy procedures that aim to ensure access for patients to MBS services that reflect modern clinical practice. It has recommended that a restriction be introduced to prevent co-claiming of item 41764 with this item because the examination of the operating space (post nasal space) and the infiltration of local anaesthetic are considered to be covered by the relevant item for adenoidectomy (41801). Refer to section 4.1.

Recommendation 2: Insertion of grommets

The Committee recommended no changes to the MBS item for insertion of grommets. However, the low rate of myringotomies performed in the Northern Territory was of concern. The serious consequences for the hearing of patients who experience difficulty accessing appropriate services has a significant impact on Indigenous communities. The Committee recommended further examination of the utilisation in this area of need. Refer to section 4.2.

Recommendation 3: Tonsillectomy

As with recommendation 1, the Committee recommended changes to items for tonsillectomy procedures to prevent co-claiming of item 41764 with this item because the examination of the operating space (post nasal space) and the infiltration of local anaesthetic are considered to be covered by the relevant items for tonsillectomy. The Committee also recommends retaining an age distinction in the item descriptor and suggests further work in relation to geographical variation is warranted. Refer to section 4.3.

Recommendation 4: Cauterisation

The Committee recommends that a minor amendment be made to remove coverage for cauterisation of the pharynx as this procedure is not considered to be appropriate clinical practice. Refer to section 4.4.

Recommendation 5: Stroboscopy

The Committee recommends that a new item be created for stroboscopy, on the basis of expert advice suggesting that stroboscopy is significantly more time consuming than standard flexible endoscopy. Refer to section 4.5.

Recommendation 6: No amendments required

The Committee identified a number of items that required no amendments. Refer to section 5.

Recommendation 7: Generic issues

The Committee has also referred a number of generic issues to the Taskforce for further consideration. Refer to section 7.

All items and descriptions are listed in Appendix A.

1.4 Consumer engagement

The Committee undertook one of the first clinical reviews. Committee members include specialist ENT surgeons, a paediatric respiratory and sleep medicine physician and a general practitioner with extensive experience in Indigenous health.

The Committee did not have a consumer representative. The Committee recommendations have been summarised in Appendix B. The summary table describes the medical service, the recommendation of the clinical experts and why the recommendation has been made for all major changes and proposed new items.

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.

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 citizens (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, being free public hospital services for public patients, subsidised drugs covered by the Pharmaceutical Benefits Scheme, and subsidised health professional services listed on the MBS.

What is the Medicare Benefits Schedule (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 What is the MBS Review Taskforce?

The government has established a MBS Review Taskforce to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients.

What are the goals of the Taskforce?

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

- △ **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-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-dates this process and has never been reviewed.
- △ **Value for the individual patient**—another core objective of the Review is to have a MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- △ **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.2 Methods: The Taskforce's approach

The Taskforce is reviewing the 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 advise on all aspects which would contribute to a modern, transparent and responsive system. This includes not only making recommendations about new items or services being added to the MBS, but also about a MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach and seize this unique opportunity to recommend changes to modernise the MBS on 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 the ongoing review of the MBS once the current Review is concluded.

As the Review is to be clinician-led, the Taskforce has decided that the detailed review of MBS items should be done by Clinical Committees. The Committees are broad based in their membership and members have been appointed in their individual capacity, not as representatives of any organisation. This draft report details the work done by the specific Clinical Committee and describes the Committee's recommendations and their rationale.

This report does not represent the final position of the Clinical Committee. A consultation process will inform recommendations of the Committee and assist it in finalising its report to the MBS review Taskforce.

Following consultation, the Clinical Committee will provide its final advice to the MBS Review Taskforce. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

2.3 Prioritisation process

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each Clinical Committee has needed to develop a work plan and assign priorities keeping in mind the objectives of the Review. With a focus on improving the clinical value of MBS services, the Clinical Committees have taken account of factors including the volume of services, service patterns and growth and variation in the per capita use of services, to prioritise their work. In addition to MBS data, important resources for the Taskforce and the Clinical Committees have included:

- △ The Choosing Wisely recommendations, both from Australian and internationally
- △ National Institute for Health and Care Excellence (NICE UK) Do Not Do recommendations and clinical guidance
- △ Other literature on low value care, including Elshaug et al's¹ Medical Journal of Australia article on potentially low value health services

- △ The Australian Commission on Safety and Quality in Health Care's (ACSQHC) Atlas of Healthcare Variation.

3. About the ENT Committee

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

3.1 Ears, Nose and Throat Surgery Clinical Committee members

Table 1: Ears, Nose and Throat Surgery Clinical Committee Members

Name	Position/Organisation	Declared conflict of interest
Mr Patrick Guiney (Chair)	Ear, nose and throat surgeon, Box Hill Hospital, Victoria; Chair, Fees Sub-Committee, Australian Society of Otolaryngology Head and Neck Surgery	Provider of MBS services
Dr John Curotta	Director, Department of Ear Nose and Throat Surgery, The Children's Hospital Westmead, Sydney	Provider of MBS services
Dr Chris Dalton	National Medical Director, Bupa Australia and New Zealand; Ear, nose and throat surgeon, Private practice, Sydney and Wollongong	Provider of MBS services
Dr Margaret-Anne Harris	Senior Medical Officer, Department of Respiratory and Sleep Medicine, Children's Health, Queensland Hospital and Health Service; Lady Cilento Children's Hospital Brisbane	Provider of MBS services
Dr Carmel Nelson	Director, Clinical Services, Institute for Urban Indigenous Health, Brisbane	Provider of MBS services
Dr David Wabnitz	Ear, nose and throat surgeon, Private practice, Adelaide	Provider of MBS services

3.2 Conflicts of interest

All members of the Taskforce, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically.

4. MBS Item Group 1 – ENT Therapeutic Procedures

4.1 Adenoidectomy MBS items

Items considered in the section

Two adenoidectomy items are considered in this section:

- △ **41800** – Adenoids, removal by GP
- △ **41801** – Adenoids, removal by specialist.

Issues identified

The Committee considered several issues in relation to the MBS items for adenoidectomy including:

- △ Co-claiming between adenoidectomy and other MBS items on the same occasion of service
- △ Whether the items should detail patient indications
- △ Whether the scope of the service reflects the MBS item

Rationale

The Taskforce identified adenoidectomy as a priority following Elshaug et al¹ identification of the service as having potentially low clinical value when provided to some patient groups. Elshaug et al cited evidence from NICE in the UK which concluded that “In the trials that evaluated the combined effect of unilateral ventilation tube insertion and adenoidectomy, the improvement in hearing level was less than that seen for the insertion of unilateral ventilation tubes alone²” and a Cochrane meta-analysis of two studies of tympanostomy tube sequelae which concluded “that it is uncertain whether adenoidectomy is effective in children with recurrent or chronic nasal symptoms. Further high quality trials are needed”.³ The UK National Health Service (NHS) Commissioning guidelines state that adenoidectomy should only be funded where performed in association with tonsillectomy or grommets.

Considerations during the review of the items for adenoidectomy

Table 2: High level MBS data on adenoidectomy, 2014–15 (date of processing)

Removal of adenoids	41800 (GP)	41801 (specialist)
Number of services 2014-15	60	10,548
MBS Benefits 2014-15	2,289	656,711
Number of providers	8	408
Number of patients	60	10,548

Unpublished data (Department of Health)

Observations on data on service usage and geographical variation

The Committee considered MBS data on service usage by age and gender, state and small geographic area (unadjusted and adjusted for population). Data was also provided on patterns of co-

claiming of adenoidectomy with MBS consultation services and other procedural services and the pattern of adenoidectomy in relation to the number of grommet insertions.

The Committee also examined data on the use of adenoidectomy in patients who also underwent insertion of grommets. The Committee proposed that for some patients, adenoidectomy is also performed to reduce the need for repeated episodes of grommet insertion. The data show that around 25 per cent of patients who underwent insertion of grommets also had an adenoidectomy on the first episode of grommet insertion. This was broadly in line with expectations.

In general, the Committee was of the view that from the data presented, there was no strong evidence that the services were being rendered inappropriately.

Structure of the items

The Committee noted that all adenoidectomies are performed in hospital and that there are a very small number of GPs providing the service.

Patient indications

The view of the Committee was that the service of adenoidectomy was a valuable clinical service, appropriate for funding through the MBS, when provided to patients with particular indications. There was a majority view that the patient indications for adenoidectomy are well-known by practitioners who perform the services.

The Committee noted that there are no published comprehensive guidelines for adenoidectomy covering all aspects of adenoid surgery. There are numerous studies looking at individual aspects of adenoid surgery, particularly in relation to otitis media. The role of adenoidectomy in obstructive sleep apnoea (OSA) is covered in literature relating to adenotonsillectomy.

Accepted common indications for adenoidectomy, alone or in combination with other procedures, include:

- △ OSA/ sleep disordered breathing (SDB) (with or without tonsillectomy)
- △ Eustachian tube dysfunction / otitis media with effusion (OME) / middle ear atelectasis (with or without ventilation tube insertion)⁴
- △ Nasal obstruction
- △ Chronic rhinosinusitis
- △ Suspected malignancy

The Committee also notes a recent study concluded that “Adjuvant adenoidectomy doubles benefit from short-stay ventilation tubes by extending better hearing through the second year in children aged 3.25-6.75 years with persistent OME with at least a 20 dB HL in both ears. The duration of benefit of adenoidectomy is related to the duration of function of the type of the ventilation tubes used. Adenoidectomy also substantially reduces eligibility for revision surgery.”⁵

The Committee considered whether the items should be amended to include patient indications for the service. The majority view of the Committee was that there was no strong evidence to justify amending the item descriptors to include patient indications.

Claiming patterns, including co-claiming of other MBS services

The Committee reviewed data on other MBS items (including consultation and procedural services) claimed on the same day, by the same practitioner, for the same patient who underwent the adenoidectomy.

The data show that adenoidectomy was the only MBS item claimed on around eight per cent of occasions. Other commonly, co-claimed items include:

- △ **41632** – Insertion of grommet (around 59 per cent of occasions for the item for tonsillectomy for under 12 year olds).
- △ **41764** – Nasendoscopic examination of the nasopharynx or larynx (around 30 per cent of occasions).
- △ **41692** – Subcutaneous resection of turbinates (around 16 per cent of occasions).
- △ **41674** – Cauterisation of septum, turbinates or pharynx (around 10 per cent of occasions).

The Committee was of the view that the service of adenoidectomy should include any examination of the post nasal space and for clarification and consistency with the service of tonsillectomy should also be amended to include the infiltration of local anaesthetic as part of the procedure.

Recommendation 1: Adenoidectomy

The Committee recommended that the item descriptor for adenoidectomy should be amended to clarify that the service includes examination of the post nasal space and local anaesthetic and that the restrictions be put in place to prevent co-claiming of adenoidectomy with item 41764.

Table 3: Proposed changes to the item descriptors

Item*	Current Item Descriptor	Proposed new Item Descriptor**
41800 G, 41801 S	Adenoids, removal of (Anaes.)	Adenoids, removal of, <u>including any examination of the postnasal space and nasopharynx and infiltration of local anaesthetic; not being a service associated with item 41764</u> (Anaes.)

* G means service is provided by a GP. S means service is provided by a specialist. **New text underlined; text to be removed struck out.

4.2 Insertion of Grommets MBS items

Items considered in this section

One item for the insertion of grommets is considered in this section:

- △ **41632** – Middle ear, insertion of tube for drainage of, (including myringotomy)

Issues identified

The Committee considered several issues in relation to the MBS items for insertion of grommets including:

- △ Service usage and geographical variation
- △ Co-claiming between adenoidectomy and other MBS items on the same occasion of service
- △ Whether the items should detail patient indications
- △ Whether the scope of the service reflects the MBS item.

Rationale

The Taskforce identified insertion of grommets as a priority following a Choosing Wisely recommendation that ear tubes should not be placed in children who have had a single episode of ear fluid lasting less than three months. Some academics have reported that there appears to be uncertainty regarding the clinical effectiveness of the procedure when compared with alternate treatments including watchful waiting or antibiotic treatment. There are a number of risks associated with the procedure including anaesthetic complications, infection, and lasting hole in the ear drum which can result in hearing loss. In addition, the ACSQHC identified hospital admission myringotomy as one of the procedures with greatest variation in service provision in Australia.

Background to review of grommet insertion

Table 4: High level MBS data on grommet insertion, 2014–15 (date of processing)

Statistic	41632
Number of services 2014-15	51,243
MBS Benefits 2014-15	\$6,491,472
Number of providers	470
Number of patients	27,080
% out of hospital	6.97%

Unpublished data (Department of Health)

Observations on data on service usage and geographical variation

The Committee considered MBS data on service usage by age and gender, state and small geographic area (unadjusted and adjusted for population). Data was also provided on the number of episodes of grommet insertion over a three-year period.

The Committee agreed that the data on age breakdown was in line with expectations. The Committee noted the data provided on the number of patients undergoing repeat episode of

grommet insertion in a three-year period which indicated that in the younger age group (0–4 year olds) around 80 per cent of patients underwent one episode of grommet insertion. The data was broadly in line with expected patterns.

ACSQHC analysis (which includes private and public admissions) demonstrated that in 2012–13 the number of myringotomies varied between 205 (Alice Spring – NT) and 1,398 (Onkaparinga) per 100,000 people aged under 18. Ten of the 14 SA3 areas with the highest rate of myringotomy were in South Australia. The other areas with the highest rates of service were the Kimberley (WA), Far North Queensland (QLD) and Warringah (NSW). MBS data showed that South Australia was the state with the highest service rates per 1,000 of population. The Committee noted the geographical variation in service rates and agreed that the higher rates in the Kimberley and Far North Queensland are encouraging and likely indicative of higher need of the population.

Data on geographical distribution of MBS services showed that the state with the highest rate of service per 100,000 of population was South Australia. Analysis on small geographical area showed that the highest service rates by population were the North Shore in Sydney, Adelaide and Perth. It noted the higher MBS services rates for insertion of grommet, which could be indicative of higher rates of private health insurance, however from the data presented, the Committee was of the view that the reason for the geographical variation cannot be determined.

Patient indications

The view of the Committee was that grommet insertion was a valuable clinical service, appropriate for funding through the MBS, when provided to patients with particular indications. There was a majority view that the patient indications for grommet insertion are well-known by practitioners who perform the services.

As with many areas in medicine and surgery, there will be individual clinical variations that will require decision-making based on clinician judgement in consultation with patients/guardians. The Committee is of the view that the main indications for grommet insertion are:

- △ OME
- △ Recurrent Acute Otitis Media (AOM).

The “Clinical Practice Guidelines: Tympanostomy Tubes in Children” published by the American Academy of Otolaryngology, Head and Neck Surgery provide a suitable guide to evidence based indications for ventilation tubes in OME and recurrent AOM.⁶

The NICE guidelines also provide appropriate guidance for management of OME in children.⁷ With respect to recurrent acute otitis media, a Cochrane review⁸ indicated significant benefit from ventilation tube insertion for AOM, defined as three or more episodes within six months, or four or more episodes within 12 months.

Further indications for grommets include:

- △ Complicated acute otitis media (e.g. facial nerve palsy, meningitis)
- △ Severe acute otitis media not responsive to conservative (medical) treatment

- △ Acute mastoiditis
- △ Middle ear atelectasis / retraction pocket disease
- △ Severe persistent eustachian tube dysfunction
- △ Prevention and treatment of middle ear barotrauma
- △ Medication administration (gentamycin, corticosteroids).

The Committee considered whether the items should be amended to include patient indications for the service. The majority view of the Committee was that there was no strong evidence to justify amending the item descriptors to include patient indications.

Claiming patterns, including co-claiming of other MBS services

The Committee was presented with data on other MBS items (including consultation and procedural services) claimed on the same day, by the same practitioner, for the same patient who had grommets inserted. The data show that on 80 per cent of occasions item 41632 was claimed twice (an occasion is defined as any episode where a tonsillectomy was performed). Other commonly co-claimed items include:

- △ **41801** – Adenoidectomy (around 21 per cent of occasions)
- △ **41789** – Tonsillectomy under 12 (around 16 per cent of occasions)
- △ **41764** – Nasendoscopic examination of the nasopharynx or larynx (around 13 per cent of occasions)
- △ **41761** – Direct examination of the post nasal space (around 5 per cent of occasions).

Recommendation 2: Insertion of grommets

The Committee recommends the following in relation to the MBS item for insertion of grommets:

- △ No change to the descriptor for item 41632 (insertion of grommet)
- △ Further work looking at the reasons for geographical variation for grommets services is warranted in the future
- △ The lower service rates of myringotomy in the Northern Territory should be further examined as it is an area of need and inadequate access to appropriate services can have serious implications for hearing problems in Indigenous populations.

4.3 Tonsillectomy MBS items

Items considered in this section

Six items tonsillectomy procedures (including arrest of haemorrhage) are considered in this section:

- △ **41788 G*** – Removal of tonsil and/or adenoids (less than 12 years)
- △ **41789 S** – Removal of tonsil and/or adenoids (less than 12 years)
- △ **41792 G** – Removal of tonsil and/or adenoids (less than 12 years or over)
- △ **41793 S** – Removal of tonsil and/or adenoids (less than 12 years or over)
- △ **41796 G** – Arrest of haemorrhage, following removal of tonsils and/or adenoids
- △ **41797 S** – Arrest of haemorrhage, following removal of tonsils and/or adenoids

*Note: G means the service is provided by a GP. S means the service is provided by a specialist.

Issues identified

The Committee considered several issues in relation to the MBS items tonsillectomy including:

- △ Underutilisation of tonsillectomies in children under 12 years suggesting significant under-treatment of OSA/SDB
- △ Service usage and geographical variation
- △ Co-claiming between tonsillectomy and other MBS items on the same occasion of service
- △ Whether the items should detail patient indications
- △ Whether the scope of the service reflects the MBS item.

Rationale

Following the Taskforce identification of adenoidectomy as a service of potentially low clinical value for some patient groups, it was considered that tonsillectomy, a related procedure, was also suitable for priority review.

The ACSQHC identified hospital admission for tonsillectomy for under 18 year olds as one of the procedures with greatest variation in service provision in Australia. Based on admitted hospital data (including public and private admissions), the ACSQHC analysis found variation in service provision ranged from 254 to 1,640 per 100,000 people in SA3 area analysis. The area with the highest rate was South Australia and the lowest rate was in rural Queensland. Excluding the outliers (the highest and the lowest rate areas), there was still a significant variation across areas with the surgical rate in one local area three times higher than in another local area.⁹

Geographical variation is not necessarily indicative of inappropriate service provision or use, but can indicate that the service warrants greater examination or consideration. Variation can be an indicator of over-servicing or under-servicing. In some circumstances geographical variation is warranted, owing to the health status and need of the population.¹⁰ In other situations, a large variation in geographical service provision can be indicative of differences in clinical practice, for example where practitioners are interpreting clinical guidelines differently, which can result in patients being over-serviced or not receiving the services that they need.¹¹ Geographical variation can also be indicative of patient access to services (for example, issues with workforce supply and/or distribution) and the relative socio-economic status of areas.

Considerations during the review of the items for tonsillectomy

Table 5: High level MBS data on removal of tonsils and adenoids under 12, 2014–15 (date of processing)

Statistic	41788 (GP)	41789 (specialist)
Number of services 2014-15	118	19,888
MBS Benefits 2014-15	\$16,333	\$4,273,410
Number of providers	9	410
Number of patients	118	19,888

Unpublished data (Department of Health).

Table 6: High level MBS data on removal of tonsils and adenoids over 12, 2014-15 (date of processing)

Statistic	41792 (GP)	41793 (specialist)
Number of services 2014-15	128	11,016
MBS Benefits 2014-15	\$23,859	\$2,909,682
Number of providers	37	433
Number of patients	128	11,016

Unpublished data (Department of Health).

Table 7: High level MBS data on arrest of haemorrhage, 2014–15 (date of processing)

Statistic	41796 (GP)	41797 (specialist)
Number of services 2014-15	10	207
MBS Benefits 2014-15	\$725	\$20,722
Number of providers	10	125
Number of patients	10	207

Unpublished data (Department of Health).

Observations on data on service usage and geographical variation

The Committee considered MBS data on service usage by age and gender, state and small geographic area (unadjusted and adjusted for population). Data was also provided on referring provider speciality and patterns of co-claiming of tonsillectomy with other MBS consultation services and procedural services.

The Committee agreed that the data on age breakdown and speciality of referring practitioner were broadly in line with expectations. The ratio of referring practitioners to patients undergoing tonsillectomy was small, indicating there does not appear to be concentrated referral patterns (for example, a small number of practitioners referring a large number of patients).

ACSQHC analysis (which includes private and public admissions) demonstrated that in 2012–13 the number of tonsillectomies varied between 254 (Tablelands – Kuranda in QLD) and 1,640 (Glenelg – South Grampians in VIC) per 100,000 people aged under 18. Local area analysis of MBS service data showed higher rates per 100,000 people in Central QLD, Perth and Canberra.

Service rates under 12 year olds

The Committee noted that the overall rates of tonsillectomy Australia wide is in the order of 0.5 per 100 children. For the major states (in terms of population), rate varies from 0.4/100 to 0.6/100. The incidence of significant OSA / SDB is in the range of 2-3/100 in the 2–10 years age group.¹² This data suggests that the number of tonsillectomies performed in this age group is well below that expected and suggests significant under-treatment of OSA/SDB. This has been previously noted in the Joint Position Paper of the Paediatrics & Child Health Division of The Royal Australasian College of Physicians (RACP) and The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) on “Indications for Tonsillectomy and Adenotonsillectomy” in 2008 which indicated that possibly as few as one in seven patients requiring tonsillectomy or adenotonsillectomy for OSA/SDB were actually receiving it.¹³

It was noted that even in the local area with the highest rate of MBS tonsillectomy (Glenelg-Grampians in Vic: 1.6 per 100 children under 12 years) there is likely under-treatment of OSA/SDB, even if it is assumed that all of these procedures were done for OSA/SDB.

There may be a number of causes for this low rate of treatment for which research would be warranted. Given the referral based MBS system, under education of GPs regarding OSA/SDB as an indication for tonsillectomy may be a possible cause of potential underutilisation for these indications.

Service rates over 12 years of age

In patients over 12 years of age the rates of tonsillectomy are substantially less (0.06 per 100 people aged over 12) with the highest rates in teenagers (0.2 per 100 people aged 13–19 years old. It can be assumed that unlike the under 12 years group, most of these are for recurrent infection. The service rate is very comparable to other similar countries (including both USA and European countries).

Geographical variation

The Committee noted the geographical variation in tonsillectomy rates, however from the data presented it was of the view that the reason for the geographical variation cannot be determined. Several possible explanations or influences on geographical variation were discussed, including:

- △ Availability of an ENT specialist and practitioners who provide paediatric anaesthetic services
- △ Socioeconomic status of the areas
- △ The possibility that some of the variation could be that clinical guidelines or recommended practice is not being consistently interpreted by some providers
- △ Varying patterns of referral by GPs

There was acknowledgement that there is no way to validate these explanations using the available data.

In general, the majority view of the Committee was that from the data presented, there was no strong evidence that the services were being rendered inappropriately.

Structure of the items

There are currently separate items for tonsillectomies on patients under 12 years (with a lower Schedule fee) and for patients over 12 years. The Committee noted that this item structure is weighted for the increased complexity of performing the service on older patients and reflects the possibility of higher complication rates in this population.

Patient indications

The view of the Committee was that tonsillectomy is a valuable clinical service, appropriate for funding through the MBS, when provided to patients with particular indications. There was a majority view that the patient indications for tonsillectomy are well-known by practitioners who perform the services.

The Committee noted that the Joint Position Paper of the Paediatrics & Child Health Division of The Royal Australasian College of Physicians (RACP) and The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) on “Indications for Tonsillectomy and Adenotonsillectomy” is a comprehensive, contemporary and locally relevant evidence based report on indications for tonsillectomy and adenotonsillectomy.

The Committee recommends that specialists and GPs review the recommendations in this paper for use of these procedures and as an aid to decision making in children with disorders related to tonsils and adenoids, with special attention to the role of tonsils and adenoids in SDB.

Further to this, the diagnostic criteria presented by Paradise¹⁴ provide a useful guide in determining significant infective events when assessing recurrent acute tonsillitis — sore throat plus at least one of the following features:

- △ Temperature > 38.3
- △ Cervical adenopathy (tender lymph nodes or lymph node size greater than 2 cm)
- △ Tonsillar exudate
- △ Culture positive for group A B-haemolytic streptococcus.

Clinicians should keep in mind that throat swabs are neither sensitive nor specific for serologically confirmed infection.

The Committee noted that the ASOHNS is in the process of developing data collection tools for the more common ENT procedures, including tonsillectomy. This data may ultimately provide useful information regarding referral patterns and indications for tonsillectomy.

The Committee considered whether the items should be amended to include patient indications for the service. The majority view of the Committee was that there was no strong evidence to justify amending the item descriptors to include patient indications.

The majority view of the Committee was that including patient indications was not appropriate as:

- △ The list of indications would make the item descriptor lengthy and complex.
- △ It would unnecessarily restrict practitioners from exercising their clinical judgement as it would not be possible to include all the circumstances where the procedure should be performed. There will always be exceptional circumstances where the service should be provided to a patient. If this circumstance is not listed in the descriptor, then the practitioner would be unable to provide a service that could benefit the patient and the patient would be unable to receive a MBS rebate for the service.
- △ The list of indications would not address the under-utilisation for indications relating to OSA/SBD.
- △ Providing guidance on appropriate practice was seen as an education/continuing professional development matter, rather than a matter that should be addressed through MBS.

Claiming patterns, including co-claiming of other MBS services

The Committee was presented with data on other MBS items (including consultation and procedural services) claimed on the same day, by the same practitioner, for the same patient who underwent the tonsillectomy.

The data show that tonsillectomy was the only MBS item claimed on around 40 per cent of occasions (an occasion is defined as any episode where a tonsillectomy was performed). Other commonly, co-claimed items include:

- △ **41632** – Insertion of grommet (around 21 per cent of occasions for the item for tonsillectomy for under 12 year olds)
- △ **41764** – Nasendoscopic examination of the nasopharynx or larynx (around 16 per cent of occasions)
- △ **18246** – Glossopharyngeal nerve, injection of an anaesthetic agent (around 12 per cent of occasions)
- △ **41761** – Direct examination of the post nasal space (around 6 per cent of occasions)

The Committee was of the view that the service of tonsillectomy should include any examination of the post nasal space and infiltration of local anaesthetic as part of the procedure.

Recommendation 3: Tonsillectomy

The Committee recommends the following in relation to the MBS items for tonsillectomy and arrest of haemorrhage:

- △ The item descriptors for tonsillectomy should be amended to clarify that the item includes examination of the post nasal space and infiltration of local anaesthetic;
- △ That restrictions be introduced to prevent co - claiming of tonsillectomy with item 41764.
- △ The age distinction for services provided to under 12 year olds and over 12 year olds should be retained in the item descriptors for tonsillectomy.
- △ Further work looking at the reasons for geographical variation for tonsillectomy services is warranted in the future.
- △ No change to the item 41796 for arrest of haemorrhage (other than removal of the fee differential between GPs and specialists).

Table 8: Proposed changes to the item descriptors

Item*	Current Item Descriptor	Proposed New Item Descriptor
41788 G, 41789 S	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (Anaes.)	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years, <u>including any examination of the postnasal space and nasopharynx and infiltration of local anaesthetic; not being a service associated with item 41764 (Anaes.)</u>
41792 G, 41793 S	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (Anaes.)	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over, <u>including any examination of the postnasal space and nasopharynx and infiltration of local anaesthetic; not being a service associated with item 41764 (Anaes.)</u>

* G means service by GP. S means service by specialist. **New text underlined.

4.4 Cauterisation by chemical means or diathermy of septum, turbinates or pharynx items

Items considered in the section

One item is considered in this section:

△ **41674** – Cauterisation by chemical means or diathermy of septum, turbinates or pharynx.

Recommendation 4: Cauterisation

The Committee recommends that a minor amendment be made to item 41674 to remove coverage for cauterisation of the pharynx as this procedure is not considered to be appropriate clinical practice. Table 9 outlines the proposed changes to the item descriptors to enact the recommendations of the Clinical Committee.

Table 9: Proposed changes to the item descriptor

Item	Current Descriptor	Proposed New Descriptor*
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum, turbinates or pharynx - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum, turbinates or pharynx - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)

* New text underlined; text to be removed ~~struck out~~.

4.5 Use of Item 41846 and Stroboscopy

Items considered in the section

One item is considered in this section:

- △ **41846** – LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic

Issues identified

MBS item 41846 is one of the highest growth items in the ENT surgery specialty. The Committee noted several issues requiring consultation including:

- △ The supraglottic, glottis and subglottic larynx may be examined under general anaesthetic or by flexible fibreoptic examination in the awake patient (in which case the appropriate item to claim is 41764)
- △ 95 per cent of item 41846 services are performed out of hospital. This suggests that this item is being inappropriately claimed by some practitioners for flexible fibreoptic examination
- △ Significant geographical variation
- △ The item is being claimed for the provision of stroboscopy

Rationale

Table 10: Key data for item 41846 (date of processing)

Descriptor start date	Total Benefits paid 2014-15	Number of services 2014-15	Total patient count 2014-15	Total provider count 2014-15	Benefits change (%) from 2011-12 to 2014-15	Services change (%) from 2011-12 to 2014-15	% Services provided out-of-hospital 2014-15
1991*	5,552,714	36,176	28,453	309	70.8%	68.9%	95.0%

* item listed in 1974. All MBS items were renumbered in 1991. Unpublished data (Department of Health)

Table 11: Number of services by state in 2014-15 – item 41846

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
27,729	1,587	4,836	996	311	105	477	135	36,176

Public data (Department of Human Services website)

Table 62: Number of services by financial year – item 41846

2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
7,731	8,308	8,914	8,945	11,662	14,102	17,594	21,418	28,479	33,148	36,176

Public data (Department of Human Services website)

The Committee was of the view that this procedure is no longer part of contemporary clinical practice. More than 95 per cent of services claimed under this item were for out-of-hospital services, and five per cent of services were provided in-hospital.

Where the service is performed under general anaesthetic as an in-hospital service, the Committee is of the opinion that this service has been superseded by microlaryngoscopy procedures (covered under items 41855 to 41867). Where the service is provided on an out-of-hospital service basis, the view of the Committee is that MBS direct examination has been superseded with the use of endoscopes and these examinations are covered under MBS item 41764.

The Committee noted that some members were aware of practitioners claiming this item for providing stroboscopy. Stroboscopy is not specifically funded under the MBS and it appears that some practitioners are using item 41846 to subsidise this service. The Committee was of the view that if the service of stroboscopy is to be MBS rebated this would be best provided for under a new item.

Public Consultation 1 December 2015 to 8 February 2016

The specific services available under Item 41846 are no longer a necessary part of contemporary practice and for this reason the Committee identified the item as obsolete. The Committee noted that some practitioners may be claiming the item when performing stroboscopy but nevertheless recommended that the item be removed. However, the Committee agreed to seek the views of stakeholders during the public consultation.

The public consultation was conducted between 1 December 2015 and 8 February 2016.

Responses from the Laryngology Society of Australasia (LSA), the ASOHNS and Speech Pathology Australia advised that item 41846 is commonly used for stroboscopy, as there is no suitable alternative MBS item for this service. The stakeholders provided evidence to support use of stroboscopy in clinical practice, with the view being that stroboscopy is accepted worldwide as the gold standard method of assessing the function of the larynx. Alternative procedures were seen as inadequate, as they increased the harm to patients by requiring them to be operated on in a surgical theatre under general anaesthetic. It was argued that removing item 41846 would increase surgical admission numbers, putting a significant cost and time burden on patients and the health system.

The stakeholders advised that the limited use of the item to certain geographical locations could be explained by the sophisticated nature of the procedure and the necessity for expensive, specialised equipment that most generalist ENT specialist practices do not have access to.

The Committee was aware of the practice of some clinicians of claiming item 41846 for stroboscopy; however, the clinical committee clearly indicated that stroboscopy should not be billed under item 41846 and should be considered for a separate service.

Following consideration of the response from stakeholders, the Committee commissioned an evidence review of stroboscopy with a view to considering the merits of introducing a separate item for the service.

Evidence Review

A rapid review of available literature was conducted in response to the following questions:

- Q1. What is stroboscopy and how is it performed? What equipment is used? How much time does the procedure take?
- Q2. For what clinical indications is stroboscopy used in Australia? Are other services regularly provided prior to, in conjunction with or as follow-up to the procedure? Is the test confined to occupational health settings (such as actors, singers) or is it also used for other patients or other pathologies?
- Q3. Who performs stroboscopy? What is the role of a speech pathologist versus an ENT surgeon?
- Q4. What is the evidence that stroboscopy has clinical utility in the diagnosis and management of vocal disorders? What is the comparator? How are vocal disorders assessed without stroboscopy? Is stroboscopy equivalent to (or better than) other methods of diagnosing vocal disorders? Does use of stroboscopy change management and/or improve outcomes for patients with vocal disorders?

A copy of the evidence review is at Appendix C. The key findings are summarised below.

Evidence Review Findings

Does the use of stroboscopy improve diagnostic accuracy and management of people presenting with vocal disorders?

- △ Laryngeal endoscopy with stroboscopy is the gold standard in the assessment of dysphonia and has no significant adverse effects.
- △ Stroboscopy is a useful diagnostic tool for evaluating functional dysphonia, vocal fold paralysis, vocal fold paresis, benign vocal fold lesions (polyps, cysts, nodules) and non-specific dysphonia. However, the report noted that the supporting evidence varied significantly.
- △ Evidence suggested that diagnostic accuracy improved when stroboscopy is interpreted by more experienced clinicians but further research in this area is required.

- △ Stroboscopy has some limitations. To synchronize the strobe light to the fundamental frequency, vocal fold vibration must be relatively periodic. It is not possible to assess intra-cycle variation and it does not record the onset and offset of phonation.
- △ The majority of studies noted that in 10 – 47 per cent of cases use of stroboscopy alters the diagnosis and treatment outcomes for the patient. This is influenced by type of lesion and type of prior investigation.
- △ Stroboscopy is widely available, cost-effective and is relatively less time and equipment intensive than alternative modalities.

The Committee accepted that the rapid evidence review properly summarised the current evidence and answered the research questions.

Further Evidence

The LSA canvassed a number of voice clinics in order to provide an estimate of the time required for a stroboscopy procedure. 'The procedure itself takes from 20–40 minutes depending on the patient's presentation but an additional 10 minutes is typically needed for frame-by-frame analysis, interpretation and reporting of results specifically related to the stroboscopic parameters. Patients undergoing a diagnostic voice analysis may undergo further assessment of acoustic and aerodynamic parameters (for example, phonatory threshold pressures, subglottal pressures and mean flow rate) so an additional 30 minutes may be required.'¹⁵ In addition, the equipment is significantly more expensive with a stroboscopic unit costing between \$50,000 to \$100,000.

Only a small number of laryngologists perform stroboscopies and the total number of stroboscopic examinations performed is roughly estimated at around 5,000 per annum.

It was noted that stroboscopy was especially relevant to patients who use their voice for occupational purposes. Services are not rebateable under the MBS if they are provided to a patient who requires treatment as a result of their occupation. However, it was noted that most patients receiving stroboscopy have a pathology that may impact on their ability to work without being directly associated with their occupation.

Recommendation 5: New item for Stroboscopy

Following consideration of the stakeholder feedback and the evidence review findings the Chair of the Committee suggests that a new item for stroboscopy should be considered on the basis of the evidence review that supports its clinical utility and the expert advice suggesting that stroboscopy is significantly more time consuming than standard flexible endoscopy.

This may warrant an MBS fee that is equivalent to item 41846 which is being used to claim the service at present. This fee is yet to be finalised.

Proposed Item Descriptor

(New text is underlined.)

Examination of glottal cycles and vibratory characteristics of the vocal folds using stroboscopy, for confirmation of diagnosis, or for treatment effectiveness where there is failure to progress or respond as expected for:

- Δ dysphonia;
- Δ vocal fold polyps and cysts;
- Δ vocal fold paralysis;
- Δ laryngeal dysplasia;
- Δ glottic carcinoma;

not being a service associated with the administration of a general anaesthetic; and not being a service to which item 41764 applies.

Fee: \$185.60 **Benefit:** 75% = \$139.20; 85% = \$157.80

5. MBS items which require no change

5.1 Items considered in this section

Four low volume items are considered in this section. The data relating to these items are at Appendix D.

- △ **41590** – Endolymphatic sac, transmastoid decompression with or without drainage of (Anaes.) (Assist.)
- △ **41614** – Round window surgery including repair of cochleotomy (Anaes.) (Assist.)
- △ **41615** – Oval window surgery, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.)
- △ **41779** – Partial pharyngectomy via pharyngotomy (Anaes.) (Assist.)

5.2 Issues identified and rationale

Item 41590 – Endolymphatic sac, transmastoid decompression with or without drainage

The Committee noted that item 41590 is not a common procedure but agreed that it is not obsolete. A number of otologists consulted by a member of the Committee advise that the procedure has largely been superseded by medical management (intratympanic gentamicin). However, it remains an option for younger patients with good residual hearing as intratympanic gentamicin carries risk of hearing loss as do most of the other destructive treatments.

Item 41614 – Round window surgery including repair of cochleotomy

The Committee agreed that there is a clinical role for the procedure described in item 41614, although it is rare. For example, this service is used for repair of endolymphatic fluid leaks and perilymph fluid leaks caused by trauma.

Item 41615 – Oval window surgery including repair of fistula

The Committee noted that there is a clinical role for the procedure described in item 41615, for example, as an alternative to stapes surgery and to repair traumatic damage.

Item 41779 – Partial pharyngectomy via pharyngotomy

The Committee noted that item 41779 is not a common procedure (1 service in 2014–15, with around 40 services over the past five years). The procedure is related to tumour surgery and the number of services is likely to fluctuate each year. Although robotic and laser surgery may be used in most cases, there will be the occasional tumour (usually tongue base or pharyngeal wall) that requires an open approach. The item may also be used for salvage surgery after previous radiation therapy. The Committee agreed that this item should be retained in the MBS.

Recommendation 6: Items requiring no change

The Committee recommended no changes to items 41590, 41614, 41615, 41779 and 41796.

6. MBS Item Group 2 – Obsolete Items

6.1 Outcome of public consultation 1 December 2015 to 8 February 2016

After a review of the items assigned to the Committee and the associated MBS data, the Committee advised that nine MBS items have no role in contemporary clinical practice as they have been replaced by more modern alternatives currently available on the MBS.

These recommendations were the subject of public consultation between 1 December 2015 and 8 February 2016.

Recommendation 7: Obsolete items

Following consideration of the response from stakeholders, the Committee and the Taskforce agreed that the following items be removed from the MBS from 1 July 2016.

- △ **11321** – Glycerol induced cochlear function changes, assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests)
- △ **18246** – Glossopharyngeal nerve, injection of an anaesthetic agent
- △ **41680** – Cryotherapy to nose in the treatment of nasal haemorrhage
- △ **41695** – Turbinates, cryotherapy to
- △ **41758** – Division of pharyngeal adhesions
- △ **41761** – Postnasal space, direct examination of, with or without biopsy
- △ **41849** – Larynx, direct examination of, with biopsy
- △ **41852** – Larynx, direct examination of, with removal of tumour

However, both the Committee and Taskforce agreed that feedback on the use of stroboscopy under item 41846 warranted a review of the evidence base with a view to considering whether item 41846 should be revised to only apply to stroboscopy, whether another existing item adequately describes the service or whether a new item is required. This item is for 'larynx, direct examination of the supraglottic, glottic and subglottic regions'. Following consideration of the evidence review and expert advice it is proposed to remove item 41846 and introduce a new item specifically for stroboscopy. Further discussion of these deliberations is at section 4.5.

7. MBS Item Group 3 – Generic issues

The Committee identified a number of issues which were not specific to ENT Surgery. These issues are being considered by the Taskforce.

7.1 Differential fees for the same service provided by GP or specialist (G & S items)

The Committee noted that there are several items in ENT which provided a differential rebate for services provided by GPs and specialists. The existence of items which distinguish between services provided by GPs and specialists are a historical artefact of the MBS, resulting from when the Schedule was based on the most common fee for the service.

The Committee supports the removal of the fee differential between GPs and specialists performing the same service.

7.2 Audit and feedback, and early engagement on potential claiming issues

The Committee noted the importance of practitioners being provided with the feedback tools to monitor and reflect on their own practice and billing. Members agreed that interquartile activity reports relating to how their MBS billing compared to their peers was a useful audit and feedback tool. The members agreed that such reporting may play an important role in moderating outlier behaviour. In the past, these reports were produced by Medicare Australia (now Department of Human Services (DHS)), however the members did not believe the reports are still available.

7.3 Aftercare

The Committee noted that the MBS currently provides guidance to practitioners about aftercare, however there is anecdotal evidence that practitioners are taking inconsistent approaches to interpretation of these rules which has cost implications for patients and for supporting appropriate use of the MBS.

The Committee recommends a broader review of aftercare and the associated rules applying across the MBS. This may be beneficial in supporting consistent practice across all practitioners, encouraging appropriate use of MBS items and to ensure that patients are not receiving differential rebates depending on the MBS billing behaviour of the individual practitioner.

7.4 Item descriptors and co-claiming of MBS services

The Committee is generally supportive of the principle that item descriptors should describe the complete medical services where possible. The Committee noted that there are inconsistent billing practices across providers of the same services, which ultimately means that patients undergoing the same types of procedures receiving different level of rebate from MBS.

The Committee noted the importance of being provided with clear guidance on how item descriptors are constructed. This is particularly important for consideration of procedural items.

The Committee is generally supportive of limiting co-claiming of subsequent consultation services on the same day as a complex procedure.

7.5 Inconsistency in referral from private providers to public services

During the discussions on the priority reviews, the Committee discussed the inconsistency across some states and territories of the ability of private practitioners to refer patients to public ENT services. The Committee noted that this could mean that a patient has a consultation in the private system, and then another in the public system.

It was noted that this practice could impact on a patient's ability to access services in a timely manner (as some patients would have to wait for a consultation with a public provider when the patient has already been assessed as suitable for intervention).

7.6 Patient indications in item descriptors

The priority reviews of tonsillectomy, adenoidectomy and grommet insertion highlight the important threshold issue when considering whether the inclusion of patient indications in item descriptors is appropriate.

The Committee were of the view that including patient indications in the item descriptors without strong evidence of inappropriate service provision may have unintended consequences for patient access to services.

It was noted that it will be not always to be possible to include all the possible patient indications in the item descriptor, and there may be patients that fall outside the indications listed in the descriptor where the practitioners' clinical judgment determines that the patient would benefit from the service. In this situation, the patient would be unable to receive a MBS rebate for the service. The absence of a MBS rebate for the service may also mean that the patient is unable to claim for the accommodation/consumables costs associated with the procedure from their private health insurer.

The Committee discussed scenarios which could be used to address exceptional circumstances, including the role of pre-authorisation processes. The general consensus was that a pre-authorisation process (similar to that used by the Pharmaceutical Benefits Scheme) may lead to delays to patients receiving treatment or intervention and may be costly to administer.

Recommendation 8: Generic Issues

The Committee made the following recommendations regarding the generic issues discussed.

- △ That DHS provide more activity reporting to individual practitioners in ways which would allow individual to compare their practice to those of their peers.
- △ That the Department of Health meet with professional specialist societies and other professional bodies regularly to discuss claiming patterns, including co-claiming, in order to identify any issues relating to potential inappropriate claiming or use of item. This would provide an opportunity for those organisations to advise on changes in clinical practice which may explain claiming variations and would allow any issues to be addressed early.

- △ The Taskforce conduct a broader review of aftercare and the associated rules applying across the MBS to support consistent practice across all practitioners, to encourage appropriate use of MBS items and to ensure that patients are not receiving differential rebates depending on the MBS billing behaviour of the individual practitioner. The Committee considered the implications of including clinical indications in item descriptors with respect to adenoidectomy, tonsillectomy and myringotomies. However, concluded that the inclusion of indications in the descriptor was unnecessary and unlikely to be helpful.

8. Recommendations Impact Statement

The recommendations relating to adenoidectomy, insertion of grommets and tonsillectomy will ensure that patients have access to MBS services that reflect modern clinical practices. They also update the MBS items to capture the current scope of the procedure being performed. The removal of MBS items which are out dated and no longer reflect modern clinical practice will encourage practitioners to provide services that are recognised by the relevant profession as reflecting current clinical practice. Practitioners will also benefit from the consolidation of some services which should minimise confusion when billing MBS items.

8.1 Targeted Consultation

The following medical colleges, craft groups, peak bodies, and consumer groups have been identified for targeted consultation:

- △ Audiology Australia
- △ Australian College of Audiology
- △ Australian College of Rural and Remote Medicine
- △ Laryngology Society of Australasia
- △ Australian Medical Association
- △ Australian Society of Otolaryngology Head & Neck Surgery
- △ Consumer Health Forum of Australia
- △ Royal Australasian College of Physicians
- △ Royal Australasian College of Surgeons
- △ Royal Australian College of General Practitioners
- △ Rural Doctors Association of Australia
- △ Speech Pathology Australia

9. References

This contains references to sources and materials referenced in this report.

- ¹ Elshaug A, et al (2012). Over 150 potentially low-value health care practices: an Australian study. *Medical Journal of Australia*, 197 (10): 556-560.
- ² National Institute for Health and Care Excellence, Surgical management of otitis media with effusion in children: NICE guidelines 60. London: NIHC; 2008.
- ³ Kay DJ, et al (2001). Meta-analysis of tympanostomy tube sequelae, *Otolaryngology - Head and Neck Surgery*;124: 374–80.
- ⁴ Kadhim A, et al (2007). Adenoidectomy for middle ear effusion: a study of 50,000 children over 24 years. *Laryngoscope*, Mar; 117(3): 427-33.

Boston M, et al (2003). Incidence of and risk factors for additional tympanostomy tube insertion in children. *Arch Otolaryngol Head Neck Surgery*, 129(3): 293-296.

Paradise JL, et al (1990). Efficacy of adenoidectomy for recurrent otitis media in children previously treated with tympanostomy tube placement. Results of parallel randomised and nonrandomised trials. *JAMA*, Apr 18; 263(15): 2066-73.

Maw AR, et al (1983). Chronic otitis media with effusion and adenotonsillectomy: prospective randomised controlled study. *Int J Pediatr Otorhinolaryngol*, Dec; 6(3): 239-46.
- ⁵ MRC Multicentre Otitis Media Study Group (2012). Adjuvant adenoidectomy in persistent bilateral otitis media with effusion: hearing and revision surgery outcomes through 2 years in the TARGET randomised trial. *Clinical Otolaryngology*, 37(2):107-16. doi: 10.1111/j.1749-4486.2012.02469.x
- ⁶ Rosenfeld RM, et al (2013). Clinical Practice Guideline: Tympanostomy Tubes in Children. *Otolaryngology Head Neck Surgery*, 149: S1-S35. .doi: 10.1177/0194599813487302.
- ⁷ National Institute for Health and Care Excellence. 2008. Otitis media with effusion in under 12s: surgery. NICE Guidelines CG60. Available at <https://www.nice.org.uk/guidance/cg60>
- ⁸ McDonald S, et al (2008). Grommets (ventilation tubes) for recurrent acute otitis media in children. *Cochrane Database of Systematic Reviews*, (4): CD004741.
- ⁹ Australian Commission on Safety and Quality in Health Care (2015). [Australian Atlas of Healthcare Variation](#). Sydney. ACSQHC.
- ¹⁰ Appleby J, et al (2011). [Variations in health care: The good, the bad and the inexplicable](#). The King's Fund.
- ¹¹ Duckett, S., Breadon, P & Romanes, D. 2015. Identifying and acting on potentially inappropriate care. *Medical Journal of Australia*, 203, 4, 183. doi:10.5694/mja15.00025
- ¹² MBS data 2014-15. Unpublished data (Department of Health).
- ¹³ Joint Position Paper of the Paediatrics & Child Health Division of The Royal Australasian College of Physicians and The Australian Society of Otolaryngology Head and Neck Surgery on [Indications for Tonsillectomy and Adenotonsillectomy](#) [PDF] (2008).
- ¹⁴ Baugh RF, et al (2011). Clinical Practice Guideline. Tonsillectomy in Children. *Otolaryngology Head Neck Surgery*, Jan; 144 (1 Suppl): S1-30.
- ¹⁵ Laryngology Society of Australia (May 2016).

10. Acronyms and Abbreviations

Term	Description
MBS	Medicare Benefits Schedule
ENT	Ear, nose and throat
ACSQHC	The Australian Commission on Safety and Quality in Health Care
NICE	National Institute for Health and Care Excellence (UK)
OSA	Obstructive sleep apnoea
SDB	Sleep disordered breathing
OME	Otitis media with effusion

11. Glossary

Term	Description
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
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 behaviours ranging from failing to adhere to particular item descriptors or rules, through to deliberate fraud.
Low-value care	Use of an intervention which evidence suggests confers no or very little benefit on patients, or that the risk of harm exceeds the likely benefit, or, more broadly, that the added costs of the intervention do not provide proportional added benefits.
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, comprising an item number, service descriptor and supporting information, Schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure, test to which the MBS item refers.
MSAC	Medical Services Advisory Committee
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"> - 100% for the item with the greatest Schedule fee - plus 50% for the item with the next greatest Schedule fee - plus 25% for each other item.
Multiple services rules (diagnostic imaging)	A set of rules governing the amount of Medicare benefit payable for multiple diagnostic imaging services provided to a patient at the same attendance (same day). See MBS Explanatory Note DIJ for more information.
Obsolete services	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Pathology episode coning	An arrangement governing the amount of Medicare benefit payable for multiple pathology services performed in a single patient episode. When more than three pathology services are requested by a GP in a patient episode, the benefits payable are equivalent to the sum of the benefits for the three items with the highest Schedule fees.
PBS	Pharmaceutical Benefits Scheme
PHCAG	Primary Health Care Advisory Group

Appendix A MBS items, Descriptors and Explanatory Notes

Otolaryngology- Diagnostic Procedure 11300-11306

Table A1: MBS items sub group 3 – otolaryngology

Item	Descriptor	Fee	Benefit
11300	BRAIN stem evoked response audiometry (Anaes.) (See para D1.9 of explanatory notes to this Category)	\$192.45	75% = \$144.35; 85% = \$163.60
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears	\$192.45	75% = \$144.35; 85% = \$163.60
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para D1.10 of explanatory notes to this Category)	\$316.95	75% = \$237.75; 85% = \$269.45
11306	Nondeterminate AUDIOMETRY (See para D1.11 of explanatory notes to this Category)	\$21.90	75% = \$16.45; 85% = \$18.65

Explanatory note D.1.9. Brain Stem Evoked Response Audiometry – (Item 11300)

Item 11300 can be claimed for the programming of a cochlear speech processor.

Explanatory note D.1.10. Electrocochleography – (Item 11304)

Item 11304 refers to electrocochleography with insertion of electrodes through the tympanic membrane.

Explanatory note D.1.11. Non-determinate Audiometry – (Item 11306)

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.13.

Audiology- Diagnostic Procedure 11309-11339

Explanatory note D.1.12. Audiology Services – (Items 11309 to 11321)

A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

- (a) in conditions that allow the establishment of determinate thresholds;
- (b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
- (c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

Explanatory note D.1.13. Oto-Acoustic Emission Audiometry – (Item 11332)

Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

Table A2: MBS items sub group 3 – audiology

Item	Descriptor	Fee	Benefit
11309	AUDIOGRAM, air conduction	\$26.30	75% = \$19.75; 85% = \$22.40
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination	\$37.15	75% = \$27.90; 85% = \$31.60
11315	AUDIOGRAM, air and bone conduction and speech	\$49.20	75% = \$36.90; 85% = \$41.85
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests	\$60.75	75% = \$45.60; 85% = \$51.65
11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests)	\$115.35	75% = \$86.55; 85% = \$98.05
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner – not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	\$32.85	75% = \$24.65; 85% = \$27.95

Item	Descriptor	Fee	Benefit
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner – being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	\$19.75	75% = \$14.85; 85% = \$16.80
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner – 1 examination in any 4 week period	\$7.90	75% = \$5.95; 85% = \$6.75
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors: (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity; or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where: the patient is referred by another medical practitioner; and middle ear pathology has been excluded by specialist opinion (See para D1.13 of explanatory notes to this Category)	\$58.55	75% = \$43.95; 85% = \$49.80
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS	\$44.60	75% = \$33.45; 85% = \$37.95
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS	\$44.60	75% = \$33.45; 85% = \$37.95
11339	ELECTRONYSTAGMOGRAPHY	\$44.60	75% = \$33.45; 85% = \$37.95
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS	\$44.60	75% = \$33.45; 85% = \$37.95

General Surgery Items – Therapeutic Procedures 30244 – 30259, 30265-30294

Table A3: MBS items – General Surgery Items – Therapeutic Procedures

Item	General Surgery Items – Therapeutic Procedures	Fee	Benefit
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	\$356.35	75% = \$267.30
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.)	\$689.80	75% = \$517.35
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.)	\$739.35	75% = \$554.55
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)	\$1,251.10	75% = \$938.35
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)	\$1,921.75	75% = \$1,441.35; 85% = \$1,843.35
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.)	\$834.05	75% = \$625.55
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)	\$1,110.65	75% = \$833.00
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)	\$445.40	75% = \$334.05
30259	SUBLINGUAL GLAND, extirpation of (Anaes.)	\$198.50	75% = \$148.90; 85% = \$168.75
30265 G	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)	\$117.55	75% = \$88.20; 85% = \$99.95
30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)	\$149.75	75% = \$112.35; 85% = \$127.30
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.)	\$149.75	75% = \$112.35; 85% = \$127.30
30272	TONGUE, partial excision of (Anaes.) (Assist.)	\$295.70	75% = \$221.80; 85% = \$251.35
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.)	\$1,762.75	75% = \$1,322.10
30282 G	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.)	\$155.40	75% = \$116.55; 85% = \$132.10
30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.)	\$204.70	75% = \$153.55; 85% = \$174.00
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.)	\$397.85	75% = \$298.40; 85% = \$338.20
30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.)	\$502.25	75% = \$376.70

Item	General Surgery Items – Therapeutic Procedures	Fee	Benefit
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.)	\$445.40	75% = \$334.05; 85% = \$378.60
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)	\$1,762.75	75% = \$1,322.10

Ear Nose and Throat- Therapeutic Procedure 31400-31412

Table A4: Ear, Nose and Throat – Therapeutic Procedure

Item	Description	Fee	Benefit
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	\$261.05	75% = \$195.80; 85% = \$221.90
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	\$301.35	75% = \$226.05
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	\$502.15	75% = \$376.65; 85% = \$426.85
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	\$1,560.15	75% = \$1,170.15
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	\$1,921.75	75% = \$1,441.35

Ear Nose and Throat- Therapeutic Procedure 41500- 41816, 41822, 41825, 41834-41886, 41904, 41907, and 41910

Table A5: Subgroup 8, Ear, Nose and Throat – Therapeutic Procedure

Item	Descriptor	Fee	Benefit
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) (See para T8.73 of explanatory notes to this Category) △ Explanatory note T.8.73. Removal of Ventilating Tube from Ear - (Item 41500) – Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.	\$82.50	75% = \$61.90; 85% = \$70.15
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)	\$238.80	75% = \$179.10; 85% = \$203.00
41506	AURAL POLYP, removal of (Anaes.)	\$144.00	75% = \$108.00; 85% = \$122.40
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)	\$162.95	75% = \$122.25; 85% = \$138.55
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)	\$585.90	75% = \$439.45
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.)	\$384.55	75% = \$288.45
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)	\$928.75	75% = \$696.60
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.)	\$988.85	75% = \$741.65
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.)	\$285.70	75% = \$214.30
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.)	\$587.60	75% = \$440.70
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.)	\$957.30	75% = \$718.00
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)	\$1,144.30	75% = \$858.25

Item	Descriptor	Fee	Benefit
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)	\$1,281.70	75% = \$961.30
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)	\$1,194.25	75% = \$895.70
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.)	\$521.25	75% = \$390.95
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.)	\$691.75	75% = \$518.85
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.)	\$1,593.05	75% = \$1,194.80
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.)	\$1,876.95	75% = \$1,407.75
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.)	\$1,194.25	75% = \$895.70
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)	\$1,478.40	75% = \$1,108.80
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.)	\$1,911.80	75% = \$1,433.85
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.)	\$1,194.25	75% = \$895.70
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.)	\$1,033.20	75% = \$774.90
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.)	\$2,435.70	75% = \$1,826.80
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.):	\$3,653.60	75% = \$2,740.20

Item	Descriptor	Fee	Benefit
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.)	\$2,435.70	75% = \$1,826.80
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.)	\$1,826.75	75% = \$1,370.10
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.)	\$2,801.55	75% = \$2,101.20
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.)	\$1,922.65	75% = \$1,442.00
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)	\$2,618.60	75% = \$1,963.95
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.)	\$1,194.25	75% = \$895.70
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.)	\$1,556.50	75% = \$1,167.40
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.)	\$1,739.50	75% = \$1,304.65
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.)	\$1,739.50	75% = \$1,304.65
41603	OSSEO-INTEGRATION PROCEDURE – implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: <ul style="list-style-type: none"> – With a permanent or long term hearing loss; and – Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and – With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. <p>Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)</p>	\$503.85	75% = \$377.90; 85% = \$428.30
41604	OSSEO-INTEGRATION PROCEDURE – fixation of transcutaneous abutment implantation of titanium fixture	\$186.50	75% = \$139.90; 85% = \$158.55

Item	Descriptor	Fee	Benefit
	for use with implantable bone conduction hearing system device, in patients: <ul style="list-style-type: none"> – With a permanent or long term hearing loss; and – Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and – With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. <p>Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)</p>		
41608	STAPEDECTOMY (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45
41611	STAPES MOBILISATION (Anaes.) (Assist.)	\$701.30	75% = \$526.00
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45; 85% = \$1,011.50
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45; 85% = \$1,011.50
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.)	\$1,895.20	75% = \$1,421.40
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)	\$824.55	75% = \$618.45
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)	\$1,194.25	75% = \$895.70
41626	ABSCCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.)	\$144.00	75% = \$108.00; 85% = \$122.40
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.)	\$521.25	75% = \$390.95
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.)	\$238.80	75% = \$179.10; 85% = \$203.00
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.)	\$1,144.30	75% = \$858.25; 85% = \$1,065.90
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.)	\$1,428.35	75% = \$1,071.30
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.)	\$47.45	75% = \$35.60; 85% = \$40.35

Item	Descriptor	Fee	Benefit
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.)	\$142.80	75% = \$107.10; 85% = \$121.40
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)	\$109.90	75% = \$82.45; 85% = \$93.45
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	\$109.90	75% = \$82.45; 85% = \$93.45
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)	\$71.95	75% = \$54.00; 85% = \$61.20
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	\$122.85	75% = \$92.15; 85% = \$104.45
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.)	\$77.55	75% = \$58.20; 85% = \$65.95
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of (<i>See para T8.76 of explanatory notes to this Category</i>)	\$82.50	75% = \$61.90; 85% = \$70.15
41665 G	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) (<i>See para T8.76 of explanatory notes to this Category</i>)	Fee: \$172.50	75% = \$129.40
41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.)	\$219.95	75% = \$165.00
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.)	\$483.25	75% = \$362.45
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.)	\$602.85	75% = \$452.15
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	\$100.50	75% = \$75.40; 85% = \$85.45
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	\$90.00	75% = \$67.50; 85% = \$76.50

Item	Descriptor	Fee	Benefit
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.)	\$162.95	75% = \$122.25; 85% = \$138.55
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.)	\$117.20	75% = \$87.90; 85% = \$99.65
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.)	\$71.95	75% = \$54.00; 85% = \$61.20
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.)	\$136.50	75% = \$102.40
41692	TURBINATES, submucous resection of, unilateral (Anaes.)	\$178.05	75% = \$133.55
41695	TURBINATES, cryotherapy to (Anaes.)	\$100.00	75% = \$75.00; 85% = \$85.00
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)	\$32.55	75% = \$24.45; 85% = \$27.70
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.)	\$91.90	75% = \$68.95
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.)	\$36.30	75% = \$27.25; 85% = \$30.90
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.)	\$448.55	75% = \$336.45
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.)	\$521.25	75% = \$390.95
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.)	\$606.50	75% = \$454.90
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.)	\$295.70	75% = \$221.80
41719	ANTRUM, drainage of, through tooth socket (Anaes.)	\$117.55	75% = \$88.20; 85% = \$99.95
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.)	\$587.60	75% = \$440.70; 85% = \$509.20
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)	\$448.55	75% = \$336.45
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.)	\$897.30	75% = \$673.00

Item	Descriptor	Fee	Benefit
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.)	\$568.65	75% = \$426.50
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.)	\$777.10	75% = \$582.85
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)	\$1,014.05	75% = \$760.55
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.)	\$483.25	75% = \$362.45
41740	FRONTAL SINUS, catheterisation of (Anaes.)	\$58.80	75% = \$44.10
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.)	\$337.45	75% = \$253.10
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.)	\$777.10	75% = \$582.85; 85% = \$698.70
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.):	\$606.50	75% = \$454.90
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.)	\$295.70	75% = \$221.80
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.)	\$46.50	75% = \$34.90; 85% = \$39.55
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.)	\$117.55	75% = \$88.20; 85% = \$99.95
41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.)	\$122.85	75% = \$92.15; 85% = \$104.45
41764	NASENOSCOPY or SINOSCOPY or FIBROPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.)	\$122.85	75% = \$92.15; 85% = \$104.45
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)	\$737.00	75% = \$552.75; 85% = \$658.60
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)	\$701.30	75% = \$526.00
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohman's operation) (Anaes.) (Assist.)	\$587.60	75% = \$440.70
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)	\$585.90	75% = \$439.45
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)	\$701.30	75% = \$526.00
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)	\$952.10	75% = \$714.10; 85% = \$873.70

Item	Descriptor	Fee	Benefit
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.)	\$1,181.15	75% = \$885.90
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.)	\$737.00	75% = \$552.75
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.)	\$568.65	75% = \$426.50; 85% = \$490.25
41788 G	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.)	\$219.95	75% = \$165.00
41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.)	\$295.70	75% = \$221.80
41792 G	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.)	\$276.80	75% = \$207.60
41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.)	\$371.50	75% = \$278.65
41796 G	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.)	\$113.70	75% = \$85.30
41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.)	\$144.00	75% = \$108.00
41800 G	ADENOIDS, removal of (Anaes.)	\$117.55	75% = \$88.20
41801 S	ADENOIDS, removal of (Anaes.)	\$162.95	75% = \$122.25
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)	\$90.00	75% = \$67.50
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.)	\$70.10	75% = \$52.60; 85% = \$59.60
41810	UVULOTOMY or UVULECTOMY (Anaes.)	\$35.60	75% = \$26.70; 85% = \$30.30
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)	\$356.35	75% = \$267.30
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.)	\$185.60	75% = \$139.20; 85% = \$157.80
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.)	\$238.80	75% = \$179.10
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)	\$356.35	75% = \$267.30
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.)	\$1,289.15	75% = \$966.90

Item	Descriptor	Fee	Benefit
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	\$1,236.05	75% = \$927.05
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	\$1,519.80	75% = \$1,139.85
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)	\$1,336.45	75% = \$1,002.35
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.)	\$185.60	75% = \$139.20; 85% = \$157.80
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.)	\$272.90	75% = \$204.70
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)	\$295.70	75% = \$221.80
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.)	\$288.20	75% = \$216.15
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)	\$494.15	75% = \$370.65
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.)	\$604.30	75% = \$453.25
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)	\$407.50	75% = \$305.65
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.)	\$613.40	75% = \$460.05
41868	LARYNGEAL WEB, division of, using microlaryngoscopic techniques (Anaes.)	\$388.70	75% = \$291.55
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.)	\$454.85	75% = \$341.15
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.)	\$587.60	75% = \$440.70; 85% = \$509.20
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.)	\$587.60	75% = \$440.70; 85% = \$509.20
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)	\$952.10	75% = \$714.10
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)	\$254.15	75% = \$190.65

Item	Descriptor	Fee	Benefit
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.)	\$401.75	75% = \$301.35
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.)	\$91.05	75% = \$68.30
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.)	\$287.90	75% = \$215.95; 85% = \$244.75
41886	TRACHEA, removal of foreign body in (Anaes.)	\$178.05	75% = \$133.55; 85% = \$151.35
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.)	\$246.50	75% = \$184.90; 85% = \$209.55
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.)	\$122.85	75% = \$92.15; 85% = \$104.45
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.)	\$390.25	75% = \$292.70

Audiology- Miscellaneous 82300-82332

Explanatory note M.15.1. Brain Stem Evoked Response Audiometry – (Item 82300)

Item 82300 can be claimed for the programming of a cochlear speech processor.

Explanatory note M.15.2. Non-Determinate Audiometry – (Item 82306)

This refers to audiometry covering those services, one or more, referred to in Items 82309-82318 when not performed under the conditions set out in paragraph M15.3.

Explanatory note M.15.3. Conditions for Audiology Services – (Items 82309 to 82318)

A service specified in Items 82309 to 82318 shall be taken to be a service for the purposes of payment of benefits if, and only if, it is rendered:

- (a) in conditions that allow the establishment of determinate thresholds;
- (b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
- (c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

Explanatory note M.15.4. Oto-Acoustic Emission Audiometry – (Item 82332)

Medicare benefits are not payable under Item 82332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

Explanatory note M.15.5. Provision of Diagnostic Audiology Services by Audiologists – (Items 82300 to 82332)

Overview

The diagnostic audiology services available through MBS items 82300 to 82332 enable an eligible audiologist to perform diagnostic tests upon written request from an Ear, Nose and Throat (ENT) specialist (a specialist in the specialty of otolaryngology head and neck surgery); or for some services, a written request from a neurologist (a specialist or consultant physician in the specialty of neurology).

These diagnostic audiology services assist ENT specialists and neurologists in their medical diagnosis and/or treatment and/or management of ear disease or related disorders. The new diagnostic audiology items supplement the existing Otolaryngology items for services delivered by, or on behalf of medical practitioners (MBS items 11300 to 11339, excluding 11304).

Requesting arrangements

Medicare benefits are payable only under the following circumstances:

- △ For items 82300 and 82306, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery;
- △ For items 82309 to 82332, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery or a specialist or consultant physician in the specialty of neurology.

The written request must be in writing and must contain:

- (a) the date of the request; and
- (b) the name of the eligible practitioner who requested the service and either the address of his or her place of practice or the provider number in respect of his or her place of practice; and
- (c) a description of the service which provides sufficient information to identify the service as relating to a particular item (but need not specify the item number).

Written requests should, where possible, note the clinical indication/s for the requested service/s.

A request may be for the performance of more than one diagnostic audiology service making up a single audiological assessment, but cannot be for more than one audiological assessment. This means that for Medicare benefits to be payable, any re-evaluation of the patient should be made at the discretion of the ENT specialist or neurologist through a separate request.

Audiologists do not have the discretion to self-determine diagnostic tests under items 82300 to 82332. If a written request is incomplete or requires clarification, the audiologist should contact the requesting ENT specialist or neurologist for further information. If an audiologist considers that additional tests may be necessary, the audiologist should contact the requesting ENT specialist or neurologist to discuss the need and if the requesting practitioner determines that additional tests are necessary, an amended or separate written request must be arranged.

It is recommended that audiologists retain the written request for 24 months from the date the service was rendered (for Medicare auditing purposes). A copy of the written request is not required to accompany Medicare claims or be attached to patients' itemised accounts/receipts or assignment of benefit forms.

Eligibility requirements for audiologists

The diagnostic audiology items (82300 to 82332) can only be claimed by audiologists who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, audiologists must meet the following requirements:

Audiologists must be either:

- △ a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or
- △ an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Registering with the Department of Human Services

Provider registration forms may be obtained from Medicare on 132 150 or at the [Department of Human Services](#).

Changes to provider details

Audiologists must notify the Department of Human Services in writing of all changes to mailing details to ensure that they continue to receive information about Medicare services.

Reporting requirements

Where an audiologist provides diagnostic audiology service/s to the patient under a written request, they must provide a copy of the results of the service/s performed together with relevant written comments on those results to the requesting ENT specialist or neurologist. It is recommended that these be provided within 7 days of the date the service was performed.

Out-of-pocket expenses and Medicare Safety Net

Audiologists can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services

Items 82300 to 82332 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 82300 to 82332 can be claimed for services provided by audiologists salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the audiologist with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

Schedules of Services

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific

items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

Table A6: Group M15 – diagnostic audiology services

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
82300	<p>Audiology health service, consisting of BRAIN STEM EVOKED RESPONSE AUDIOMETRY, performed on a person by an eligible audiologist if:</p> <ul style="list-style-type: none"> (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11300 applies has not been performed on the person on the same day. <p><i>(See para M15.1 and M15.5 of explanatory notes to this Category)</i></p>	\$153.95	85% = \$130.90	\$461.85
82306	<p>Audiology health service, consisting of NON-DETERMINATE AUDIOMETRY performed on a person by an eligible audiologist if:</p> <ul style="list-style-type: none"> (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and 	\$17.50	85% = \$14.90	\$52.50

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
	<p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11306 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.2 and M15.5 of explanatory notes to this Category)</i></p>			
82309	<p>Audiology health service, consisting of an AIR CONDUCTION AUDIOGRAM performed on a person by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p> <p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> i. a specialist in the specialty of otolaryngology head and neck surgery; or ii. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11309 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>	\$21.05	85% = \$17.90	\$63.15
82312	<p>Audiology health service, consisting of an AIR AND BONE CONDUCTION AUDIOGRAM OR AIR CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM performed on a person by an eligible audiologist if:</p>	\$29.70	85% = \$25.25	\$89.10

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
	<p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p> <p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> iii. a specialist in the specialty of otolaryngology head and neck surgery; or iv. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11312 applies has not been performed on the person on the same day.</p>			
	<p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>			
82315	<p>Audiology health service, consisting of an AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM performed on a person by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p> <p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> i. a specialist in the specialty of otolaryngology head and neck surgery; or v. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p>	\$39.35	85% = \$33.45	\$118.05

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
	<p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11315 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>			
82318	<p>Audiology health service, consisting of an AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM WITH OTHER COCHLEAR TESTS performed on a person by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p> <p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> i. specialist in the specialty of otolaryngology head and neck surgery; or ii. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11318 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>	\$48.60	85% = \$41.35	\$145.80

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
82324	<p>Audiology health service, consisting of an IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (not being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p> <p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> i. a specialist in the specialty of otolaryngology head and neck surgery; or ii. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11324 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>	\$26.30	85% = \$22.40	\$78.90
82327	<p>Audiology health service, consisting of an IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and</p>	\$15.80	85% = \$13.45	\$47.40

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
	<p>(b) the eligible practitioner is:</p> <ul style="list-style-type: none"> i. a specialist in the specialty of otolaryngology head and neck surgery; or ii. a specialist or consultant physician in the specialty of neurology; and <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is performed on the person individually and in person; and</p> <p>(f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and</p> <p>(g) a service to which item 11327 applies has not been performed on the person on the same day.</p> <p><i>(See para M15.3 and M15.5 of explanatory notes to this Category)</i></p>			
82332	<p>Audiology health service, consisting of an OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by an eligible audiologist on an infant or child in circumstances in which:</p> <p>(a) the service is performed pursuant to a written request made by an eligible practitioner who is:</p> <ul style="list-style-type: none"> i. a specialist in the specialty of otolaryngology head and neck surgery; or ii. a specialist or consultant physician in the specialty of neurology; and <p>(b) the infant or child is at risk due to 1 or more of the following factors:</p> <ul style="list-style-type: none"> i. admission to a neonatal intensive care unit; ii. family history of hearing impairment; iii. intra-uterine or perinatal infection (either suspected or confirmed); iv. birthweight less than 1.5kg; 	\$46.85	85% = \$39.85	\$140.55

Item	Descriptor	Fee	Benefit	Extended Medicare Safety Net Cap
	<ul style="list-style-type: none"> v. craniofacial deformity; vi. birth asphyxia; vii. chromosomal abnormality, including Down Syndrome; viii. exchange transfusion; and 			
	<ul style="list-style-type: none"> (c) middle ear pathology has been excluded by specialist opinion; and (d) the infant or child is not an admitted patient of a hospital; and (e) the service is performed on the infant or child individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11332 applies has not been performed on the infant or child on the same day. 			
	<p><i>(See para M15.4 and M15.5 of explanatory notes to this Category)</i></p>			

Appendix B Summary for consumers

This appendix describes the medical service, recommendation of the clinical experts and why the recommendation has been made. Items annotated with a G are provided by a GP, while those annotated with an S are provided by a specialist.

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 1: Adenoidectomy				
41800 G, 41801 S – removal of adenoids	Surgery to remove adenoids which are the lymph nodes in the throat behind the nose. Infected adenoids can cause middle ear infections, sinusitis and difficulty breathing.	<ul style="list-style-type: none"> △ Amend the item to: <ul style="list-style-type: none"> – include examination of the space where the operation will take place plus the injection of local anaesthetic. – prevent co-claiming with item 41764. △ That GPs and specialists be paid the same amount for the procedure. 	<ul style="list-style-type: none"> △ The descriptors will clarify which procedures are included the items. △ The items will not be claimable with item 41764. This is not expected to affect patients. △ The recommendation regarding different fees for GPs and specialists will be considered by the Taskforce. 	The services provided under item 41764 are already included within the existing tonsil removal items.

Item	What it does	Committee Recommendation	Why
Recommendation 2: Insertion of Grommets			
41632 – Insertion of grommets	A tube is placed into the eardrum so that air can flow into the middle ear to treat glue ear and chronic middle ear infections	<p>△ No amendments to the descriptor recommended.</p> <p>△ Investigation of geographical variation for grommet services is warranted.</p>	No change as Committee agreed service reflects current clinical practice.
Myringotomy	An incision in the eardrum to drain fluid or pus	△ Investigation for low service rates in the Northern Territory is warranted.	There may be serious consequences for a patient's hearing if they cannot access appropriate services. This has a significant impact, especially on Indigenous communities.

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 3: Tonsillectomy				
<p>△ 41788 G, 41789 S – Removal of tonsils, or tonsils and adenoids in a person aged less than 12 years</p> <p>△ 41792 G, 41793 S – Removal of tonsils, or tonsils and adenoids in a person aged 12 years or over</p>	<p>The tonsils and adenoids help to fight infections by producing antibodies. However sometimes they become infected and enlarge to block the upper airway, leading to breathing difficulty. So they may need to be removed.</p>	<p>△ Amend the items to:</p> <ul style="list-style-type: none"> – explain that the item for this service includes examination of the operating space as well as the injection of local anaesthetic. – to prevent co-claiming with item 41764 <p>△ The Committee has also recommended to the Taskforce that GPs and specialists be paid the same amount for the procedure.</p> <p>△ Investigation for geographical variation for tonsillectomy services warranted.</p>	<p>△ The item descriptions will be updated to clarify which procedures are included the items.</p> <p>△ The items will no longer be able to be claimed with item 41764. This is not expected to affect patients.</p>	<p>△ The Committee reviewed evidence from the Australian Commission on Safety and Quality in Health Care, the Royal Australasian College of Physicians and the Australian Society of Otolaryngology for best practice in diagnosis and treatment.</p> <p>△ The services provided under item 41764 are already included within the existing tonsil removal items.</p>
<p>41796 G, 41797 S – Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia</p>	<p>Procedure to stop bleeding after tonsils, or tonsils and adenoids have been removed.</p>	<p>The Committee recommended to the Taskforce that GPs and specialists be paid the same amount for the procedure</p>	<p>For consideration by the Taskforce</p>	<p>The Taskforce will consider this issue more broadly.</p>

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 4: Cauterisation				
41674 – Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates or pharynx	<p>△ Cauterisation and diathermy use heat to seal off blood vessels or destroy abnormal cells. Chemical cauterisation uses acid to destroy tissue.</p> <p>△ These procedures are used on the septum (nostrils); turbinates (tissue inside each nostril) and pharynx (cavity behind the nose and mouth).</p>	Amend the item to remove reference to the pharynx.	<p>△ Cauterisation and diathermy of the septum and turbinates will continue to be available under this item.</p> <p>△ This item will no longer include the pharynx.</p>	Cauterisation and diathermy of the pharynx are not considered to be appropriate in modern clinical practice. Patients will benefit by because this change to the item supports practitioners to provide clinically appropriate services.

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 5: Stroboscopy				
41846 – Direct examination of the supraglottic, glottic and subglottic regions of the larynx	Examines parts of the larynx (voice box) under general anaesthetic	Remove this item.	<p>Direct examination of the larynx has been superseded by:</p> <ul style="list-style-type: none"> - existing items 41855 to 41867 for microlaryngoscopy for in hospital services - endoscopic procedures covered under MBS item 41764 for out-of-hospital services 	<p>△ The item has been superseded by more modern MBS items.</p> <p>△ The Committee advise that it would be difficult to examine the subglottic region without general anaesthetic.</p> <p>△ When this item is claimed as part of a larger procedure, the examination component is included within the larger procedure.</p> <p>△ See below for stroboscopy.</p>
New Service – Stroboscopy	Uses a fast flashing strobe light and camera to take snapshots of the vocal cords to identify problems that may be causing voice disorders.	A new item for stroboscopy, on the basis of advice suggesting stroboscopy may be more time consuming than standard flexible endoscopy.	At present stroboscopy is being billed under item 1846. These services could transfer to a new item.	Evidence suggests that stroboscopy may be useful in assessing voice disorders such as hoarseness.

Recommendation 6: items requiring no change

Item	What it does
41590	Endolymphatic sac, transmastoid decompression with or without drainage
41614	Round window surgery including repair of cochleotomy
41615	Oval window surgery including repair of fistula
41779	Partial pharyngectomy via pharyngotomy
41796/41797	Tonsils or tonsils and adenoids, arrest of haemorrhage

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 7: Obsolete items				
11321 – Glycerol induced cochlear function changes (Klockoff’s tests)	Four separate tests to measure hearing	Remove this item as it is rarely used because it has been replaced by more modern tests which are available on the MBS. (note, this item was removed from the MBS on 1 July 2016)	Patients will benefit from better quality health care because doctors will be encouraged to provide more modern alternative testing which should support better outcomes for patients.	There are more modern alternatives available on the MBS such as electronystagmography (item 11339)
18246 – Glossopharyngeal nerve – injection of anaesthetic	An injection of local anaesthetic into the glossopharyngeal nerve which can affect taste; the tongue, tonsils, pharynx; and some of the muscles used in swallowing. Under the MBS it is mainly used with items for tonsillectomy and uvulopalatopharyngoplasty ((UPPP)	Remove this item. (note, this item was removed from the MBS on 1 July 2016)	The MBS item for a tonsillectomy or UPPP already includes a component for the injection of local anaesthetic.	Clinical evidence indicates there is a risk of serious upper airway obstruction and diminished gag reflex.

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 7: Obsolete items				
	sleep surgery to remove and/or remodel tissue in the throat)			
41680 – Cryotherapy to nose in treatment of nasal haemorrhage	Uses freezing techniques (e.g. gas or liquid nitrogen) to treat nose bleeds.	Remove this item. (note, this item was removed from the MBS on 1 July 2016)	If this procedure is needed to treat acute conditions it can be claimed under existing MBS item 41677 (arrest of nasal haemorrhage).	This procedure is out dated and does not reflect modern clinical practice.
41695 – Turbinates, cryotherapy to	Uses freezing techniques (eg. gas or liquid nitrogen) on bones in the nose, generally to remove obstructions.	Remove this item. (note, this item was removed from the MBS on 1 July 2016)	There are other more modern existing MBS items which may be used for this service.	<p>△ This service is out dated and no longer reflects modern clinical practice.</p> <p>△ It has very low utilisation and usage continues to decline.</p>
41758 – Division of pharyngeal adhesions	Surgery to cut abnormal tissue that creates a band on the pharynx (the passage that leads from the nose and mouth to the voice box and oesophagus).	Remove this item. (note, this item was removed from the MBS on 1 July 2016)	There are several other existing MBS items which are currently being used for this service.	<p>△ This service is out dated and no longer reflects modern clinical practice.</p> <p>△ It has very low utilisation (3 services in 2014-15).</p>
41761 – Postnasal space, direct examination of, with or without biopsy	Surgery to examine the back of the nose for excess tissue or disease. A biopsy may also be performed. It is used to diagnose disease and develop a treatment plan.	Remove this item. (note, this item was removed from the MBS on 1 July 2016)	This change will improve access for patients to more modern endoscopic procedures for which there are existing MBS items.	<p>△ This procedure described in this item is out dated and does not reflect modern clinical practice.</p> <p>△ Where the postnasal space is examined as part of another procedure, the examination</p>

Item	What it does	Committee Recommendation	What would be different	Why
Recommendation 7: Obsolete items				
				of the operating space is considered to be part of the primary procedure.
41849 – Direct examination of the larynx with biopsy	Examination of the larynx (voice box) to perform a biopsy to diagnose disease; or remove a tumour.	Remove the items. (note, these items were removed from the MBS on 1 July 2016)	If the service is performed using a scope, an MBS item for microlaryngoscopy (items 41855 to 41867) or endoscopic examination should be claimed.	Other MBS items provide a rebate for procedures that use more modern techniques and equipment. The recommendation will improve the quality of service patients receive.
41852 – Direct examination of the larynx with removal of tumour				

Recommendation 8: Generic issues	
Committee Recommendation	Why
That DHS provide more activity reporting to individual practitioners.	This would enable individual doctors to compare their billing patterns of their specialty so that they can see whether their practice reflects that of the rest of their specialty.
That the Department meet regularly with organisations representing doctors to discuss claiming patterns, including co-claiming.	This would provide an opportunity for discussion on changes in clinical practice which may affect claiming and would allow any issues to be addressed early.
That the Taskforce review the rules relating to aftercare (treatment by a doctor, or on behalf of a doctor, following an operation).	To encourage consistent practice by doctors and appropriate use of MBS items.

Appendix C Stroboscopy Review

This report is a rapid review of available literature regarding the questions specified, not a systematic review. As in the literature, stroboscopy, videostroboscopy and strobovideolaryngoscopy are used interchangeably to refer to the combined use of strobe lighting and an endoscope with camera and video recording capabilities.

Q1. What is stroboscopy?

Vocal cords vibrate at a rate too rapid for real time viewing. A stroboscope is an instrument used to make cyclically moving objects appear slower moving or stationary. Stroboscopy is one method by which clinicians are able to visualise vocal fold vibration, and uses a synchronised, flashing light, which passes through a flexible or rigid endoscope.⁽¹⁾ The frequency of the strobe light is adjustable and set either equal to, lower or higher than that of the moving object in order to create a visual representation of motion. Videostroboscopy combines the use of high definition videolaryngoscopy with stroboscopy, which allows improved image resolution, light sensitivity and increased number of images recorded per second.⁽²⁾ In creating a visual estimate of vocal cord vibratory cycles, important information may be gathered regarding vocal cord vibration properties and potential vocal cord pathology as well as creating a record of examination.⁽¹⁾

The main application of stroboscopy is in examination of the vibratory characteristics of the glottal cycle. A visual estimate is achieved through synchronised images over several glottal cycles, enabling examination of quasiperiodic vibration of the vocal fold.⁽²⁾ Both opening and closing phases of the vocal folds may be analysed to assess velocity, symmetry and smoothness of movement. One may also assess mucosal wave propagation, which is an important indicator of the pliability of the superficial layer of the lamina propria. Pathologic changes in vocal fold vibratory behaviour may be indicated by alterations in mass, stiffness and tension. Masses such as keratin cysts may result in a reduction or absence of mucosal wave, whilst vocal fold stiffness may be suspected with reduced oscillation or asymmetry.⁽²⁾ Tension of the vocal folds will also result in reduced ability to oscillate, though such changes are usually symmetrical.

(a) How is stroboscopy performed?

In rigid strobolaryngoscopy, the patient is seated, leaning forward with neck flexed and head extended. Topical anaesthetic is applied and microphone calibrated. The endoscope is inserted with tongue protruded and retracted anteriorly. Optimal examination requires clear visualisation of the subepithelial vasculature of the vocal fold. The patient is taken through a series of vocal tasks at low, mid and high frequency pitches and variable volumes.⁽¹⁾

In flexible strobolaryngoscopy, the patient is similarly positioned, with nose and nasopharynx anaesthetised and decongested. The scope is passed through the nose and positioned above the larynx, with similar examination to rigid strobolaryngoscopy.⁽¹⁾

(b) What equipment is used?

A videostroboscopic unit contains stroboscopic light source and microphone, video camera, endoscope and video recorder. Either flexible or rigid endoscopes may be used. Whilst flexible endoscopy allows examination from a variety of angles, there have been issues with low light intensity and reduced resolution. These potential issues have been significantly improved through the use of distal-chip technology. Rigid telescopes are optimal for assessment of mucosal pliability due to improved magnification and illumination, however are dependent upon the patient tolerance, cooperation and relevant anatomical considerations. ⁽¹⁾

Q2. For what clinical indications is stroboscopy used in Australia?

Laryngeal endoscopy with stroboscopy has been said to be the gold standard in the assessment of vocal fold function. ⁽³⁾ There do not appear to be Australian guidelines as to the use of stroboscopy in assessment of dysphonia, however the American Academy of Otolaryngology guidelines from 2009⁽⁴⁾ state that stroboscopy should be considered where hoarseness symptoms are out of proportion to laryngoscopic examination. Stroboscopic light enables assessment of vocal fold pliability, enabling other pathologies such as vocal fold scars easier to identify. This guideline points to stroboscopy as resulting in an altered diagnosis in up to 47 per cent of cases, and aiding in the differentiation of pathologies such as polyps and cysts. ⁽⁴⁾

Videostroboscopy has been used to assess both pathology and function, and to assist in selecting patients for surgical intervention. ⁽⁵⁾ It has even been suggested that stroboscopy be considered in the clinical assessment of acute laryngeal trauma without imminent risk of airway compromise. ⁽⁶⁾

Vocal fold polyps and cysts

Shohet in a retrospective study of 32 patients, found mucosal wave to be absent or diminished in 100 per cent of vocal fold cysts, and present or increased in 80 per cent of vocal fold polyps.⁽⁷⁾ They concluded that stroboscopic evaluation of mucosal wave assisted in differentiation of cysts and polyps and provided relevant information for surgical intervention. ⁽⁷⁾

Quriba et al found irregular vocal fold edges and absent mucosal wave to be significant factors in differentiating between cysts and polyps. They also found irregularity of vocal fold edges and symmetry between vocal folds to be highly correlated with the degree of dysphonia, and a lower but still significant correlation between dysphonia and phase closure. ⁽⁸⁾

Vocal fold paralysis

A 2015 cross-sectional study of otolaryngologist diagnosis of vocal fold paresis showed 72 per cent of physicians to rely on stroboscovideolaryngoscopy for diagnosis, with the strongest positive predictive value for sluggish vocal fold motion, decreased adduction and abduction and decreased vocal fold tone.⁽⁹⁾

Harries et al in an analysis of stroboscopic findings in 100 patients with unilateral vocal cord paralysis, found reliable stroboscopic signals in patients with paralysed fold close to the midline. ⁽¹⁰⁾

Laryngeal dysplasia

There are few studies concerning the use of stroboscopy in identifying laryngeal dysplasia specifically, with variable conclusions as to its utility in this group of patients. A prospective study by Djukic et al⁽¹¹⁾ involved 112 patients with laryngeal dysplasia, treated over a 2 year period. They reviewed features on stroboscopy, including glottal occlusion, phase symmetry, periodicity, amplitude, mucosal wave and non-vibratory segments. It was found that amplitude of vocal fold vibrations in patients with mild dysplasia was a significant indicator of recurrence, though none of the other signs were significantly associated with disease progression.⁽¹¹⁾

Glottic carcinoma

Invasive carcinoma can cause a disruption of the superficial lamina propria of the vocal folds, which may be signified by a reduction in amplitude and mucosal wave propagation.⁽¹²⁾ The depth, size and location of a tumour may influence management, with an abnormal mucosal wave suggesting the need for more extensive treatment such as radiotherapy, CO₂-laser removal or surgical excision. Stroboscopy enables an examination of mucosal wave propagation, and therefore gives an indication of tumour depth.⁽¹²⁾ El-Demerdash et al found the sensitivity and specificity of videostroboscopy in predicting the invasive nature of glottic lesions, based on absence or reduction of the mucosal wave, to be 96.8 per cent and 92.8 per cent respectively.⁽¹³⁾

A recent systematic review by van Balkum et al⁽¹²⁾ found moderate quality evidence to support the utility of stroboscopy in excluding invasive disease, although it does not appear to be of additional value in establishing the diagnosis of glottis carcinoma. Conversely, another recent meta-analysis and systematic review by Mehlum et al found videostroboscopy to have a range of sensitivities and specificities from 86-100 per cent and 7-93 per cent respectively, indicating an ability in general to identify cancer, but being able to accurately exclude cancer in only around 65 per cent of patients.⁽¹⁴⁾ The authors in van Balkum however, noted the heterogeneity of studies and small sample sizes, indicating a need for further research in this area. ⁽¹²⁾

(a) Are other services regularly provided prior to, in conjunction with or as follow-up to the procedure

The number and type of concurrent or subsequent services associated with videostroboscopy depends upon clinical presentation and pathological findings. In general, a patient would undergo thorough history taking and examination, along with qualitative and quantitative assessments of phonation. Speech pathologist involvement is common, as is review by other relevant medical specialists where required. Initial direct visualisation of the larynx, followed by further investigation by endoscopy, stroboscopy or other techniques may follow dependent upon certainty of diagnosis and severity of symptoms. ⁽¹⁵⁾

(b) Is the test confined to occupational health settings (actors, singers etc) or is it also used for other patients or other pathologies

Hoarseness and dysphonia (despite the former being a symptom and the latter a diagnosis) are often used interchangeably to indicate an alteration in vocal quality, pitch, loudness or effort that impairs communication or reduces voice-associated quality of life.⁽⁴⁾ Causes of hoarseness are numerous, and can be broadly divided into congenital, inflammatory, metabolic or neurological disorders, trauma, tumours, age-related voice change or sulcus vocalis.⁽¹⁶⁾

As stroboscopy can assist in the evaluation of frequency, periodicity, amplitude, symmetry, glottic closure and mucosal wave propagation, its use has not been restricted to those in the occupational health setting. Rather, it is seen as an invaluable tool in assessing a wide variety of patients presenting with dysphonia.⁽¹⁾

Q3. Who performs stroboscopy? What is the role of a speech pathologist versus an ENT surgeon?

In Australia, it is an ENT surgeon, usually with specialisation in laryngology, who performs videostroboscopy in the assessment of dysphonia. The official position of the American Speech-Language-Hearing Association (ASHA) is that endoscopy is within the scope of practice for speech language pathologists with specialised training for the “purpose of evaluating and treating disorders of speech, voice, resonance, and swallowing function”.⁽¹⁷⁾ In several North American states, speech and language pathologists are able to perform endoscopy including stroboscopy, under otolaryngologist supervision, for functional assessment of swallow. However, not all states have endorsed this scope of practice and of those that have, many restrict such scope to a functional assessment, without provision of a medical diagnosis or administration of anaesthetic.⁽¹⁸⁾

Speech pathologists evaluate voice disorders using perceptual, acoustic, aerodynamic and laryngeal imaging methods including videolaryngostroboscopy to inform diagnosis, assess impairment and monitor progress.⁽¹⁹⁾ Voice therapy may be utilised in distinguishing between diagnoses, as an adjunct to medical or surgical intervention, or as stand-alone management.⁽¹⁹⁾ Patients in whom speech pathology intervention has been shown to be effective include those with muscle tension dysphonia, benign vocal fold lesions, age-related vocal fold atrophy, neurological disorders and reflux-related vocal dysfunction.⁽¹⁹⁾

Q4. What is the evidence that stroboscopy has clinical utility in the diagnosis and management of vocal disorders?

There have been numerous studies over the years to support the utility of stroboscopy as a diagnostic tool in the evaluation of dysphonia.⁽²⁰⁻²²⁾ Videostroboscopy continues to be widely used by otolaryngologists not only because of role in diagnostic voice assessment, but its wide availability, relative ease of use and cost effectiveness.⁽²³⁾

As mentioned previously, it provides information as to vibratory and dynamic characteristics of the vocal folds during phonation, however does have some limitations. Firstly, in order for synchronization of the strobe light to the fundamental frequency to occur, vocal fold vibration must be relatively periodic. It is also not possible to assess intra-cycle variation; given stroboscopy samples images over several vibratory cycles.⁽²⁴⁾ Finally, videostroboscopy is not capable of recording the onset and offset of phonation.⁽²⁴⁾

There have also been questions relating to the inter-rater reliability of stroboscopy in assessing various features of vocal cord function, with some studies having found poor reliability particularly in examination of glottal closure and vocal fold symmetry.⁽²⁵⁾ A recent systematic review also noted greater reliability in ratings of anatomical features than functional features, particularly phase symmetry.⁽³⁾ However, they did note that the majority of studies had failed to describe the method used to test rater reliability as well as other relevant factors such as number and experience level of raters.⁽³⁾ Mehta et al also noted that that variability amongst studies relating to inter-rater reliability tended to be influenced by the laryngeal feature being rated, type of rating scheme and skill-level of examiners.⁽²³⁾

(a) What is the comparator? How are vocal disorders assessed without stroboscopy?

(b) Is stroboscopy equivalent to (or better than) other methods of diagnosing vocal disorders?

As stroboscopy refers to the lighting source (strobe vs continuous) and not the endoscopic procedure per se, it is difficult to identify a true comparator. Whilst continuous light laryngoscopy is said to be useful in assessing the anatomy of laryngeal lesions and supraglottic constriction, laryngostroboscopy is considered more useful in assessing amplitude, vibratory features and glottis closure.⁽²⁶⁾

Videostroboscopy may employ the use of either flexible or rigid endoscopes, though few studies directly compare the two. Singh et al performed a prospective pilot study involving 24 patients undergoing stroboscopic evaluation of their neoglottis using either flexible or rigid endoscopes. They found flexible videostroboscopy to be better tolerated and allowed further analysis of mucosal wave patterns.⁽²⁷⁾

The literature appears to predominantly compare videostroboscopy to other visualization techniques including microlaryngoscopy and more recently high-speed digital imaging and videokymography. Each is briefly discussed below.

Microlaryngoscopy

Microlaryngoscopy is carried out by suspension laryngoscopy with general anaesthesia, and provides improved visualization with magnification and enables palpation of the vocal cords.⁽²⁸⁾

Akbulut et al compared rigid videolaryngostroboscopy with microlaryngoscopy in the diagnosis of benign vocal cord lesions in 85 patients with 199 lesions identified during the latter. 58 lesions,

involving 50.6 per cent of patients were diagnosed only by microlaryngoscopy, with the majority of lesions missed by videolaryngostroboscopy being structural abnormalities such as sulcus vocalis, vascular ectasia, cysts and mucosal bridge.⁽²⁸⁾ It was noted that many of the lesions missed were pathologies such as mucosal bridge, which may only be diagnosed on microlaryngoscopy with direct palpation and meticulous examination of the vocal cords.⁽²⁸⁾

Dailey et al, in a retrospective review of 100 patients, found microlaryngoscopy to have found an additional 16 lesions in nine patients, with four of the nine patients undergoing a management change intra-operatively.⁽⁵⁾ Again the vast majority of these additional lesions were sulci or mucosal bridges.⁽⁵⁾

High –speed digital imaging / high-speed videolaryngoscopy

High-speed videolaryngoscopy (HSV) allows images to be recorded at considerably faster rates than stroboscopy, and allows vibratory movement to be visualized in detail regardless of regularity of behaviour. HSV is able to view onset and offset, phonatory breaks and laryngospasm, which occurs too quickly to be picked up on stroboscopy.⁽²⁴⁾ Technologies involving high-speed imaging are relatively new compared with stroboscopy, and have not as yet developed as significant an evidence base. However evidence to date appears to conclude that there is no significant difference in reliability of measures obtained from HSV and videostroboscopy with the exception of assessment of periodicity and symmetry.^(29, 30) Video stroboscopy is more easily able to identify aperiodic vibrations, whilst HSV has been shown to be more sensitive in evaluating phase asymmetry.^(23, 29) HSV however, is said to be more expensive, less widely available, necessitates greater storage capacity and is highly dependent upon the skill and experience of the examiner.^(31, 32)

The following table (taken from Krausert et al⁽³³⁾) compares various features of high-speed imaging with videostroboscopy.

Table C1: Comparison of current mucosal wave imaging techniques - Rows refer to different techniques, while columns describe attributes. Compared cost includes maintenance and long-term use; compared cost and compared resolution are based on a scale of 0 (least costly, lowest resolution) to 3 (most costly, highest resolution).

Technique	Purpose	Compared cost	Frame rate	Compared resolution	Best use
Stroboscopy	Visualization of periodic vocal fold vibration, mucosal wave patterns	1	30 frames per second	3	Initial evaluative
Videokymography (VKG)	Quantitative and qualitative description of periodic and aperiodic vocal fold vibration, mucosal wave pattern	2	8,000 lines per second	1	Supplement to stroboscopy
High Speed Digital Imaging (HSDI)	Detailed visualization of periodic and aperiodic vocal fold vibration, mucosal wave patterns	3	4,000 frames per second	2	Supplement to stroboscopy
Electroglottography	Describes duration, coordination, relative contact patterns within glottal cycle	0	n/a	n/a	In tandem with VKG, or HSDI

It is quite difficult to make many conclusions from the above comparisons. Whilst available evidence regarding microlaryngoscopy appears to conclude that it is diagnostically more accurate, this improved rate may be dependent upon the type of lesion involved. High-speed imaging technology is continuing to emerge, but due to the expense, expertise required in interpretation and requirement for additional equipment, this has been said to be preferred as an adjunct to videostroboscopy. As mentioned previously, the diagnostic accuracy of videostroboscopy itself is difficult to infer due to great variability amongst the evidence in terms of inter and intra-rater reliability. There is a suggestion amongst the literature that reliability is improved when stroboscopy is interpreted by more experienced clinicians, however as many of the relevant studies fail to provide sufficient information regarding this, further research in this area is required.

(c) Does use of stroboscopy change management and/or improve outcomes for patients with vocal disorders?

There are numerous studies that have found the use of stroboscopy to have resulted in a change in management in a proportion of cases, although there is considerable variation in terms of magnitude of change. The majority of studies have noted a change in management of between 10 and 47%, influenced of course by type of lesion and type of prior investigation.⁽³⁴⁾

Casiano et al in a study of 292 dysphonic patients undergoing videolaryngoscopy with and without stroboscopic examination, found the addition of stroboscopy to alter diagnosis and treatment outcomes in 14 per cent of patients.⁽²¹⁾

Printza et al conducted a study of 150 patients with benign laryngeal disease or dysphonia without known cause.⁽³⁵⁾ They found that stroboscopy established the pathological cause in 28.8 per cent of cases, and altered management choice in 4.7 per cent. In 32.2 per cent of cases, stroboscopy added information regarding cause of dysphonia.⁽³⁵⁾ Fritz et al in a recent case series involving patients referred with a diagnosis of laryngopharyngeal reflux, found that stroboscopy was relied upon to alter the diagnosis in 83.1 per cent of patients referred by another otolaryngologist.⁽³⁶⁾

A 2013 prospective observational study by Halawa et al analysed four stroboscopic parameters (glottis closure, vocal fold vibration, mucosal wave and phase symmetry) before and after vocal rehabilitation, stratified by clinical course.⁽³⁷⁾ A statistically significant relationship was found between stroboscopic parameters and clinical course, supporting the utility of stroboscopy not only in diagnostic differentiation, but also in assessment of clinical progression.⁽³⁷⁾

Discussion

The value of stroboscopy has been well established in the literature, particularly in the diagnosis of functional dysphonia and vocal fold paralysis. Improved illumination and magnification enables detailed examination of glottic closure, mucosal wave and amplitude, improving detection of subtle vocal fold pathology otherwise missed by indirect laryngoscopy.⁽²¹⁾ A retrospective analysis of a U.S. claims database looked at factors associated with utilization of videostroboscopy. They found that videostroboscopy was associated with specific diagnoses included vocal fold paresis, benign vocal fold lesions (polyps, cysts, nodules) and non-specific dysphonia.⁽³⁴⁾

Clinical use of stroboscopy has appeared to increase with improvements in endoscopic and imaging technologies. There are suggestions in the literature that stroboscopic principles will continue to be necessary, with supplementation by newer technologies to improve image capture rate and resolution.

The main discrepancy in the literature regarding the use of stroboscopy is related to inter and intra-rater reliability, though the evidence does suggest that reliability is improved with interpretation by highly experienced and trained clinicians. There is also evidence that stroboscopy is more useful in the assessment of certain characteristics including mucosal wave.

It is clear, that stroboscopy plays an important role in the investigation of dysphonia, and aside from the limitations associated with the visualization technique itself, has no significant adverse effects. In addition, it is widely available, cost-effective and is relatively less time and equipment intensive than alternative modalities. Further research into stroboscopy may be required to clarify some of the outstanding doubts, however it currently remains the gold standard for investigation of dysphonia.

References

1. Bryson P. [Stroboscopy](#): Medscape; 2015.
2. Sataloff RT. Sataloff's Comprehensive Textbook of Otolaryngology: Head & Neck Surgery: Six Volume Set: Jaypee Brothers, Medical Publishers Pvt. Limited; 2015.
3. Bonilha H, Focht K, Martin-Harris B. Rater Methodology for Stroboscopy: A Systematic Review J Voice. 2015;29(1):101-8.
4. Schwartz S, Cohen S, Dailey S, Rosenfeld R, Deutsch E, Gillespie M, et al. Clinical Practice Guideline: Hoarseness (Dysphonia). Otolaryngol Head Neck Surg. 2009;141(3):supp S1-S31.
5. Dailey S, Spanou K, Zeitels S. The Evaluation of Benign Glottic Lesions: Rigid Telescopic Stroboscopy Versus Suspension Microlaryngoscopy. Journal of Voice. 2007;21(1):112-8.
6. Kennedy T, Gilroy P, Millman B, Greene J, Pellitteri P, Harlor M. Stroboscovideolaryngoscopy in the Management of Acute Laryngeal Trauma. Journal of Voice. 2004;18(1):130-7.
7. Shohet J, Courey M, Scott M, POssoff R. Value of videostroboscopic parameters in differentiating true vocal fold cysts from polyps. Laryngoscope. 1996;106(1):19-26.
8. Quriba A, Darweesh M. Voice changes and laryngo-video-stroboscopic findings in patients with vocal fold polyps and cysts. Egypt J Otolaryngol. 2015;31:47-53.
9. Wu A, Sulica L. Diagnosis of vocal fold paresis: current opinion and practice. Laryngoscope. 2015;125(4):904-8.
10. Harries M, Morrison M. The role of stroboscopy in the management of a patient with a unilateral vocal fold paralysis. J Laryngol Otol. 1996;110(2):141-3.
11. Djukic V, Milovanovic J, Jotic A, Vukasinovic M. Stroboscopy in Detection of Laryngeal Dysplasia Effectiveness and Limitations. Journal of Voice. 2014;28(2):e14-e21.
12. van Balkum M, Buijs B, Donselaar E, Erkelens D, Fernandes G, Wegner I, et al. Systematic review of the diagnostic value of laryngeal stroboscopy in excluding early glottic carcinoma Clin Otolaryngol. 2016;00:000.
13. El-Demerdash A, Fawaz S, Sabri S, Sweedd A, Rabie H. Sensitivity and specificity of stroboscopy in preoperative differentiation of dysplasia from early invasive glottic carcinoma. Eur Arch Otorhinolaryngol. 2015;272:1189-93.
14. Mehlum C, Rosenberg T, AGroentved A, Dyrvig A, Godballe C. Can Videostroboscopy Predict Early Glottic Cancer? A Systematic Review and Meta-analysis. Laryngoscope. 2015;doi: 10.1002/lary.25745.
15. Sulica L. Laryngoscopy, Stroboscopy and Other Tools for the Evaluation of Voice Disorders. Otolaryngol Clin N Am. 2013;46:21-30.
16. Havas T. [Hoarseness and voice dysfunction](#): Australian Doctor; 2012.
17. ASHA. [Use of endoscopy by speech-language pathologists: position statement](#): American Speech-Language-Hearing Association 2008.
18. ASHA. [ASHA Talking Points on SLPs Performing Endoscopy for Swallowing Assessment](#) 2007.
19. Cohen S, Dinan M, Kim J, Roy N. Otolaryngology Utilization of Speech-Language Pathology Services for Voice Disorders. The Laryngoscope. 2016;126:906-12.
20. Woo P, Colton R, Casper J, Brewer D. Diagnostic calue of stroboscopic examination in hoarse patients. Journal of Voice. 1991;5(3):231-8.
21. Casiano R, Zaveri V, Lundy D. Efficacy of videostroboscopy in the diagnosis of voice disorders. Otolaryngol Head Neck Surg. 1992;107(1):95-100.
22. Sataloff RT, JR S, Hawkshaw M. Stroboscovideolaryngoscopy: results and clinical value. Ann Otol Rhinol Laryngol. 1991;100(9 Pt 1):725-7.

23. Mehta D, Hillman R. Current role of stroboscopy in laryngeal imaging. *Curr Opin Otolaryngol Head Neck Surg.* 2012;20(6):429-36.
24. Tsuji D, Hachiya A, Dajer M, Ishikawa C, Takahashi M, Montagnoli A. Improvement of Vocal Pathologies Diagnosis Using High-Speed Videolaryngoscopy. *Int Arch Otorhinolaryngol.* 2014;18:294-302.
25. Nawka T, Konerding U. The interrater reliability of stroboscopy evaluations. *J Voice.* 2012;26(6):812.
26. Yiu E, Lau V, Ma E, Chan K, Barrett E. Reliability of Laryngostroboscopic Evaluation on Lesion Size and Glottal Configuration: A Revisit. *The Laryngoscope.* 2014;124:1638-44.
27. A S, Kazi R, Venkitaraman R, Kapoor K, Nutting C, Clarke P, et al. Does flexible videostroboscopy compare with rigid videostroboscopy in the assessment of the neoglottis? A preliminary report. *Clin Otolaryngol.* 2008;33:56-66.
28. Akbulut S, Altintas H, Oguz H. Videolaryngostroboscopy versus microlaryngoscopy for the diagnosis of benign vocal cord lesions: a prospective clinical study. *Eur Arch Otorhinolaryngol.* 2015;272(1):131-6.
29. Kendall K. High-Speed Laryngeal Imaging Compared With Videostroboscopy in Healthy Subjects. *Arch Otolaryngol Head Neck Surg.* 2009;135(3):274-81.
30. Mendelsohn A, Remacle M, Courey M, Postma G. The diagnostic role of high-speed vocal fold vibratory imaging. *J Voice.* 2013;27(5):627-31.
31. Kazi R, Rhys-Evans P, Nutting C, Harrington K. The great debate: Stroboscopy vs high-speed imaging for assesment of alaryngeal phonation *J Can Res Ther.* 2009;5(2):121-3.
32. Nunez-Batalla F, Senaris-Gonzalez B, Corte-Santos P, Sevilla-Garcia M, Coca-Pelaza A, Charlone-Granucci R, et al. The Diagnostic Role of Direct Microlaryngoscopy. *Acta Otorrinolaringol Esp.* 2007;58(8):362-6.
33. Krausert C, Olszewski A, Taylor L, McMurray J, Dailey S, Jiang J. Mucosal Wave Measurement and Visualization Techniques. *J Voice.* 2012;25(4):395-405.
34. Cohen S, Thomas S, Roy N, Kim J, Courey M. Frequency and Factors Associated with Use of Videolaryngostroboscopy in Voice Disorder Assessment. *Laryngoscope.* 2014;124(9):2118-24.
35. Printza A, Triaridis S, Themelis C, Constantinidis J. Stroboscopy for benign laryngeal pathology in evidence based health care *Hippokratia.* 2012;16(4):324-8.
36. Fritz M, Persky M, Fang Y, Simpson C, MAmin M, Akst L, et al. The Accuracy of the Laryngopharyngeal Reflux Diagnosis: Utility of the Stroboscopic Exam. *Otolaryngol Head Neck Surg.* 2016;pii: 0194599816655143.:1-6.
37. Halawa W, Garcia A, Perez S. Effectiveness of laryngostroboscopy for monitoring the evolution of vocal nodules after rehabilitator treatment *Auris Nasus Larynx.* 2013;40:204-6.

Appendix D Data for items requiring no change

Item 41590

Table D1: Item 41590 – Description

Description	Fee	Benefit
Endolymphatic sac, transmastoid decompression with or without drainage of (Anaes.) (Assist.)	\$1,194.25	75% = \$895.70

Table D2: Item 41590 – Key data for item (date of processing)

Descriptor start date	Total Benefits paid 2014-15	Number of services 2014-15	Total Patient count 2014-15	Total provider count 2014-15	Benefits Change (%) from 2011-12 to 2014-15	Service Change (%) from 2011-12 to 2014-15	% services provided out-of-hospital 2014-15
1991	9,464	13	13	8	-47.3%	-38.1%	0.0%

Unpublished data (Department of Health).

Table D3: Item 41590 – Number of services by state in 2014–15

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
7	2	2	0	0	2	0	0	13

Public data (Department of Human Services website).

Table D4: Item 41590 – Number of services by financial year

2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
32	36	20	20	24	17	15	21	37	14	13

Public data (Department of Human Services website).

Item 41614

Table D5: Item 41614 – Description

Description	Fees	Benefit
ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45; 85% = \$1,011.50

Table D6: Item 41614 – Key data for item (date of processing)

Descriptor start date	Total Benefits paid 2014-15	Number of services 2014-15	Total Patient count 2014-15	Total provider count 2014-15	Benefits Change (%) from 2011-12 to 2014-15	Service Change (%) from 2011-12 to 2014-15	% services provided out-of-hospital 2014-15
1991	81,567	177	168	24	71.3%	77.0%	1.1%

Unpublished data (Department of Health).

Table D7: Item 41614 – Number of services by state in 2014–15

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
113	5	6	9	43	0	0	1	177

Public data (Department of Human Services website).

Table D8: Item 41614 – Number of services by financial year

2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
79	90	74	56	57	66	87	100	127	182	177

Item 41615

Table D9: Item 41615 – Description

Description	Fee	Benefit
OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.)	\$1,089.90	75% = \$817.45; 85% = \$1,011.50

Table D10: Item 41615 – Key data for item (date of processing)

Descriptor start date	Total Benefits paid 2014–15	Number of services 2014–15	Total Patient count 2014-15	Total provider count 2014–15	Benefits Change (%) from 2011-12 to 2014–15	Service Change (%) from 2011-12 to 2014–15	% services provided out-of-hospital 2014–15
1994	15,707	20	20	14	-24.9%	-31.0%	0.0%

Unpublished data (Department of Health).

Table D11: Item 41615 – Number of services by state in 2014–15

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
1	5	3	4	7	0	0	0	20

Public data (Department of Human Services website).

Table D12: Item 41615 – Number of services by financial year

2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
41	23	27	24	28	22	30	29	31	28	20

Item 41779

Table D13: Item 41779 – Description

Description	Fee	Benefit
PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)	\$701.30	75% = \$526.00

Table D14: Item 41779 – Key data for item (date of processing)

Descriptor start date	Total Benefits paid 2014–15	Number of services 2014–15	Total Patient count 2014–15	Total provider count 2014–15	Benefits Change (%) from 2011-12 to 2014–15	Service Change (%) from 2011-12 to 2014–15	% services provided out-of-hospital 2014–15
1991	526	N/P*	N/P*	N/P*	-83.6%	-87.5%	0.0%

Unpublished data (Department of Health).

Table D15: Item 41779 – Number of services by state in 2014–15

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
0	1	0	0	0	0	0	0	1

Public data (Department of Human Services website).

Table D16: Item 41779 – Number of services by financial year

2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
6	3	3	9	13	2	12	8	6	10	1

Public data (Department of Human Services website).

**Addendum to the
First Report from the
Ear Nose and Throat (ENT) Surgery
Clinical Committee - Tonsillectomy,
Adenoidectomy & Insertion of
Grommets**

2016

A.1 Public Consultation

The Thoracic Medicine Clinical Committee report was released for public consultation on 9 September 2016 for four weeks.

A.2 Ear, Nose and Throat Surgery Clinical Committee review of public consultation submissions

The Ear, Nose and Throat Surgery Clinical Committee assessed the submissions from public consultation.

The Committee noted the main themes included:

- △ that removal of obsolete item 41846 for examination of post nasal space should not be removed and should continue to be paid as a separate item. Also, removal should not occur before the new stroboscopy item is implemented; and
- △ disagreement with the co-claiming restriction between item 41764 and the adenoidectomy and tonsillectomy items.

A.3 Amended item description

The Committee considered public consultation feedback and agreed that no changes were required to the recommendations; and only one change was required to the new stroboscopy item descriptor.

The stroboscopy item descriptor was changed to include the recording of the glottic cycle and amend one indication, as shown below (and on page 27).

Amended proposed stroboscopy item descriptor:

Examination AND RECORDING of glottal cycles and vibratory characteristics of the vocal folds using stroboscopy, for confirmation of diagnosis, or for treatment effectiveness where there is failure to progress or respond as expected for:

- △ dysphonia;
- △ BENIGN VOCAL CORD LESIONS;
- △ vocal fold paralysis;
- △ laryngeal dysplasia;
- △ glottic carcinoma;

not being a service associated with the administration of a general anaesthetic; and not being a service to which item 41764 applies.