Australian
Private Hospitals
Association

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Dear Professor Robinson

The Australian Private Hospitals Association (APHA) is appreciative of being given an opportunity to respond to the targeted consultation letter on the Medicare Benefits Schedule (MBS) Review Taskforce – recommendations from the Gastroenterology Clinical Committee review of colonoscopy MBS items.

According to the Australian Institute of Health and Welfare (AIHW) the private hospital sector (both private day and overnight hospitals) provided roughly 3 in 4 fibreoptic colonoscopies (with or without excision) in Australia in 2016-17 (AIHW 2018).

Whilst the draft recommended colonoscopy items are an improvement on previously sighted items, a few outstanding issues remain, especially around implementation in the private sector. These issues are around the level of detail of supporting evidence required and concerns arising from the specification of time intervals between repeat colonoscopy. There are also a number points for clarification that will be essential to providers for implementation and practical purposes.

In raising these concerns, APHA recognises and supports the intention of the proposed reforms to reduce the inappropriate use of colonoscopies.

Level of detail in supporting evidence required

The level of detail required in new items 2 and 3 will at times be difficult to implement. The processes that will need to be in place to gather the supporting evidence are not currently in place and will inhibit patients from receiving the care they need.

If for example a person is a new patient to the facility, the facility will be entirely reliant on supporting information from the referring general practitioner. However, patient history information is not always included in the referral, in which case the facility will not be able to proceed based on the proposed draft items.

Additionally, some of the required information (for example; size and number of polyps) is not currently coded, and therefore will not be available. Currently, polyps are coded according to the highest grade polyp, not all polyps. The information required is not always supplied on pathology reports.

Patients who are new to a facility may not remember when they had their last colonoscopy and who performed it, let alone what was found. Patients are not always a reliable source of this information.

Intervals between repeat colonoscopy

The draft items are inflexible as to the intervals of care, and there may be medico-legal implications in the future if plaintiffs argue a shorter interval may have improved their clinical outcomes. With this in mind it is recommended that there be a shorter interval available for item 2, section B, and that use of a faecal occult blood test (FOBT) be recognised as important in this group.

As these items are currently drafted, there is no provision for repeat colonoscopies in case of poor results due to poor preparation. Currently, if a patient has poor preparation prior to their colonoscopy, it is a judgement call by the gastroenterologist as to when the patient should return for a repeat colonoscopy. For example, if the gastroenterologist reached the caecum and felt they had reasonable visibility, then they may be willing to let the patient go five years until their next colonoscopy, however, they may require the patient to return sooner if the preparation caused murky visibility. The patient should not be penalised (and potentially have cancers or other issues overlooked) due to poor preparation.

Finally we note that these recommendations implicitly assume that colonoscopies will be performed well on every occasion and that the results will be of a consistent quality. In reality there is variation in the quality of detection and reporting such that one clinician may detect more issues where another has found fewer or none. Different colonoscopy providers have differing levels of expertise and therefore their patients develop interval cancers at different rates. The MBS Review should consider whether an additional item number would be appropriate to allow provision of a second opinion or a subsequent more frequent colonoscopy where indicated by the results of the prior examination.

Implementation and practicality

The APHA strongly supports the recommendation the Gastroenterological Society of Australia be commissioned to undertake provider education regarding the use of the new items, prior to their implementation. The APHA suggests there should also be education and training for referrers and pathology providers, especially if detailed supporting evidence will remain a requirement.

Questions raised with APHA to be resolved in the education phase include:

- Will the intervals come into effect upon the first use of the new item numbers?
- Could item 8 be clarified to its meaning.

Clarity is essential particularly in defining those matters where clinicians will have scope to exercise judgment and those matters that are fixed in defining the new MBS items noting that both health services and health insurers will be reliant of clear definitions for the purposes of approving benefits and for the purposes of enabling informed financial consent.

We would also recommend that these changes be supported by education for consumers so that they understand the role of colonscopies in the management of overall bowel health.

Yours sincerely

Lucy Cheetham
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2 November 2018