

**ROYAL AUSTRALASIAN COLLEGE OF SURGEONS**

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**MBS REVIEW – RACS RESPONSE TO  
GASTROENTEROLOGY CLINICAL COMMITTEE REPORT**

**Date**

**7 October 2016**

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training, and high standards of practice in Australia and New Zealand. RACS is the trusted and acknowledged authority on surgery, and our Fellows and staff work closely with other health organisations to promote the best health outcomes for patients and the community.

RACS affirms the key goals of the MBS review to deliver better patient outcomes as a result of a thorough scientific and economic assessment of the MBS items and associated rules. We appreciate the opportunity to comment on the Report from the Gastroenterology Clinical Committee. Overall the College is supportive of the measures outlined by the Clinical Committee, which are aimed at reforming item numbers and assessing areas where there is need for further review.

RACS submits the following feedback regarding the recommendations contained in the Medicare Benefits Schedule Review Taskforce – Report from Gastroenterology Clinical Committee (August 2016).

## **RESPONSES TO CONSULTATION RECOMMENDATIONS**

RACS provides the following responses and comments:

### **Recommendation 1**

Agree that co-claiming of item numbers 32090 and 32093 should not occur.

### **Recommendation 2**

RACS advises that combined gastroscopy & colonoscopy can occur for many reasons – no need to pursue this currently from clinical perspective. To claim one-half of 30473 is 'small' cf. inappropriate use of 32093.

### **Recommendation 3**

RACS believes that capsule endoscopy needs review. Whilst it has a role, rarely does it lead to therapeutic intervention. It is not useful acutely and there are now better modalities (fine cut CT, MRI) looking for small bowel masses or Crohn's disease.

### **Recommendation 4**

Agree that 30473 and (30478-9) are sufficient.

RACS advises that repeating gastroscopies – 30473 - has become a clinical phenomenon and this needs review. The indications for a repeat gastroscopy in less than one year are small.

### **Recommendation 5**

Agree. One fee, labelled 30475, is appropriate.

### **Recommendation 6**

RACS agrees that the revised descriptor is appropriate. Routine intubation of terminal ileum is not recommended and is rarely important clinically – assessment ileo-caecal Crohns or indeterminate colitis.

### **Recommendation 7**

It may not be possible to combine these procedures on all occasions.

**Recommendation 8**

RACS notes the growth of these expensive procedures (Balloon Enteroscopy) and recommends they be assessed by MSAC and their therapeutic value considered. (p 55-57).

**Recommendation 9**

The management of large sessile polyps is controversial: several repeated EMRs compared to resection. MSAC should look into this too.

**Recommendation 10**

Removal of obsolete articles is reasonable.

**In addition to these responses to the recommendations, RACS would also like to raise the following general issues:**

*Fee Recommendation*

- Specific fee recommendations for 32090 and 32093: The College affirms that the schedule of fees A1-9 are reasonable. A10 should be a rare patient and the considered approach is colonoscopic not surgical. (p 29)
- In relation to the fees described on page 29, the relationship of these to the previous group is done well. For example, A10 would expect to actually be B10. Audit regarding these numbers will be important.
- The list is also quite long for busy clinicians, so this needs consideration. Considering the pace and interruptions of clinical practice, the possibility for error is increased.

*Referral*

- RACS believes that the requirement to check with Medicare regarding patient eligibility for colonoscopy services is onerous.
- RACS affirms the importance of appropriate referral letters and adequate patient history being provided. Current practice means that people still arrive with 'referral for colonoscopy' and history is provided by the patient completely. This raises the risk of potential recall issues.

*Claiming*

- Failed preparation in symptomatic patients is a consideration regarding the fee (maybe halfway between 32084 & 32090). Note that only some of these patients will need another scope if CT colonoscopy is available. It should be noted that this is not common from a clinical perspective.
- Regarding endoscopic ultrasound and ERCP – RACS believes co-claiming should be permitted if skill set and clinical scenario & support allow. There will still be two separate procedures required in some clinical scenarios. (p 52-54).
- Claiming 104 in open-access situation for scopes is reasonable. Whilst brief – and even in screened open access situations – the procedure may need to be altered (thus consent) and medical issues are common. For example, patients have not had bowel preparation, may have taken their usual insulin, have not stopped warfarin or NOAC, or had a cardiac event between referral and arriving for the scopes.

*Procedures*

- In relation to Radiofrequency ablation procedures (Barrett's, reflux –Stretta), these are highly controversial and few clinicians are performing these. Overall the evidence base for Stretta is poor and consumables associated with it are expensive.
- The relatively higher growth rate of 32093 is of concern and is not explained by NBSCP.
- Experienced clinicians consider that the proportion that are 32093 (of total 32090+32093) should be 25-30%. In 2003-4 it was 28%, In 2014-15 it was 43% (p 24).

- RACS notes that combined Gastroscopy & Colonoscopy, may reflect awareness of Barrett's, increased patients with FH gastric carcinoma, older refluxing patients who have previously been asymptomatic on PPIs. (p 35-36). This may actually reflect good clinical practice.