Medicare Benefits Schedule Cardiac Surgical Services

MBS changes effective from 1 July 2021

Australian Government
Department of Health

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Welcome and Introduction

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Dr Andrew Singer is Principal Medical Adviser in the Australian Government Department of Health, advising on policy and issues involving acute care, healthcare safety and quality, the Medical Benefits Schedule Review as well as medical education, training and workforce. He is an Associate Professor in the Australian National University Medical School, as well as Emergency Senior Specialist at Canberra Health Services. Andrew is a former Censor-in-Chief and President of the Australasian College for Emergency Medicine and has been on the executive with the International Federation for Emergency Medicine. He is a Director and Committee Chair with the Australian Medical Council.

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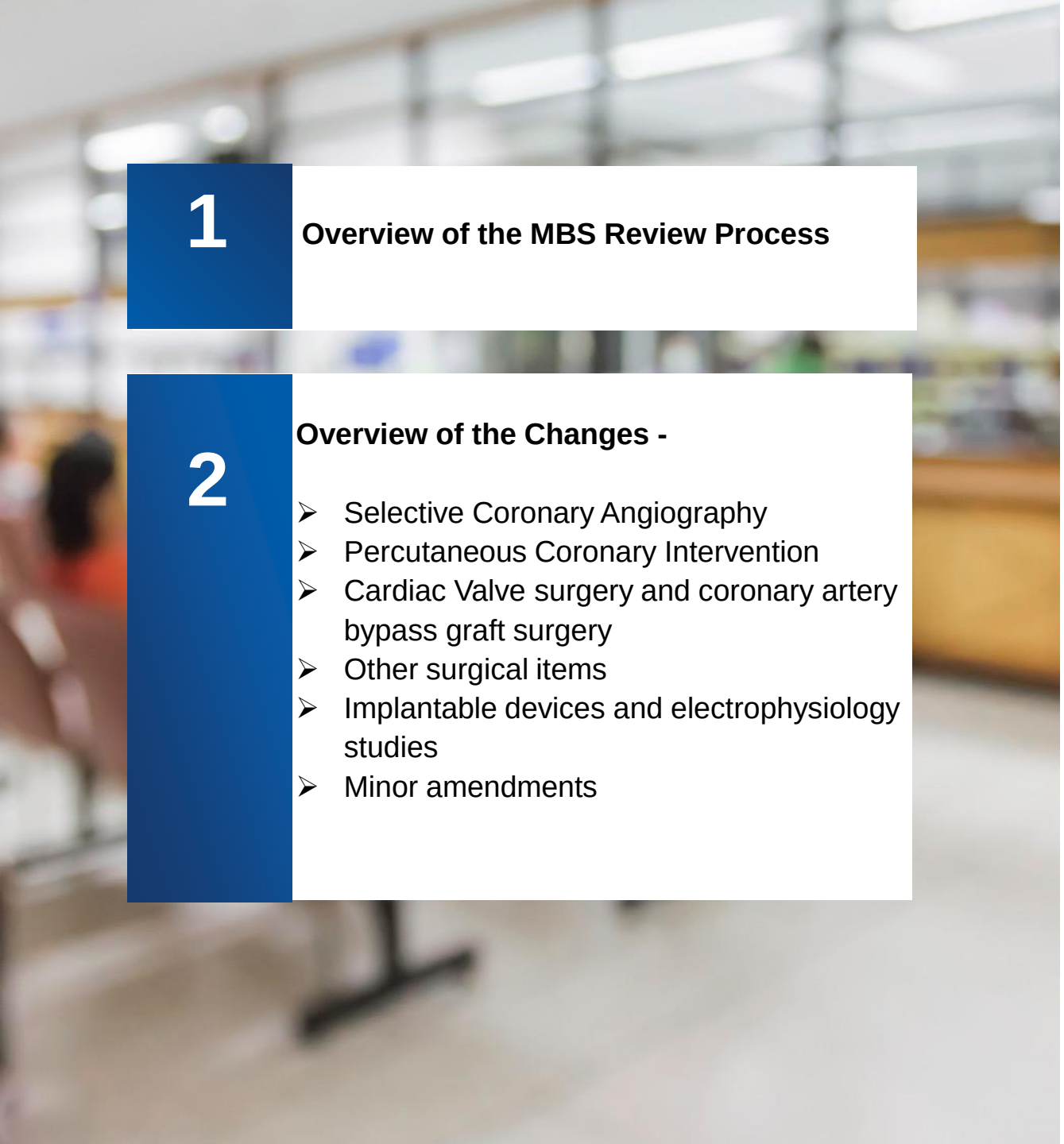


1 **Overview of the MBS Review Process**

2 **Overview of the Changes -**

- Selective Coronary Angiography
- Percutaneous Coronary Intervention
- Cardiac Valve surgery and coronary artery bypass graft surgery
- Other surgical items
- Implantable devices and electrophysiology studies
- Minor amendments

Today's session

Medicare Benefits Schedule

Changes to MBS cardiac surgical services

Phase 2 Cardiac services changes

- 1 July 2021

Achieving a modern and sustainable Medicare

- The MBS supports delivery of over 400 million health services a year
- Over the next 4 years the MBS will outlay over $100 billion, with expenditure expected to exceed $30 billion per annum within the next two years.
- A modern and sustainable Medicare program must support access to high-quality and effective services.
- It must also support services that reflect current clinical evidence and contemporary best medical practice.

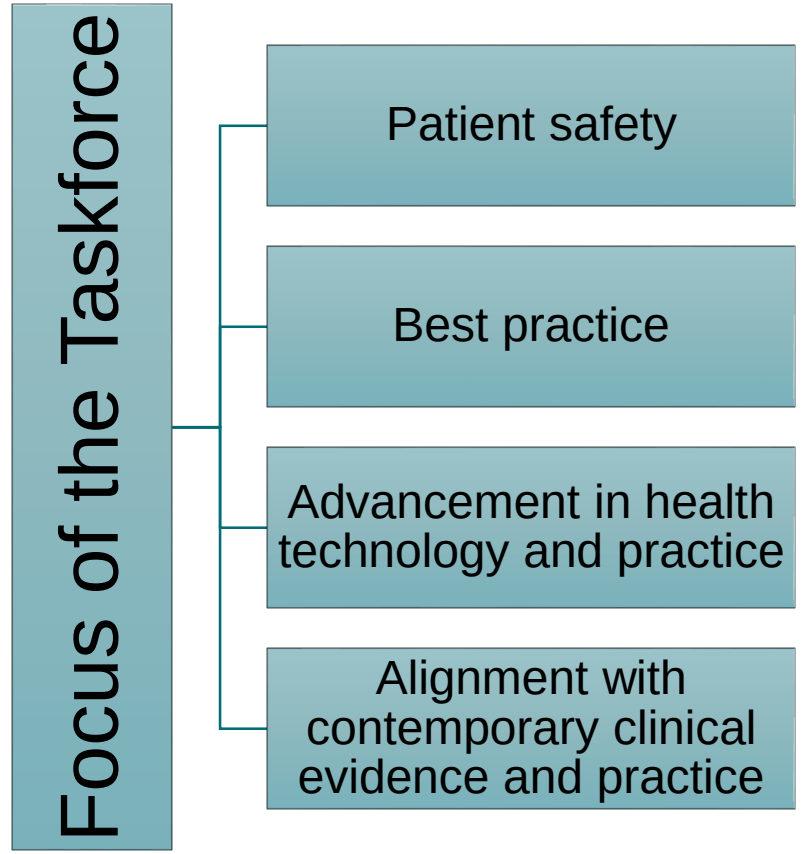
Achieving a modern and sustainable Medicare

- Changes to Medicare-funded cardiac procedural services ensure:
  - They reflect current medical practice
  - Support high value care
  - Patients receive procedures in line with current best practice
- These changes follow recommendations from the Medicare Benefits Schedule (MBS) Review Taskforce

The MBS Review

The MBS Review Taskforce was established in 2015:

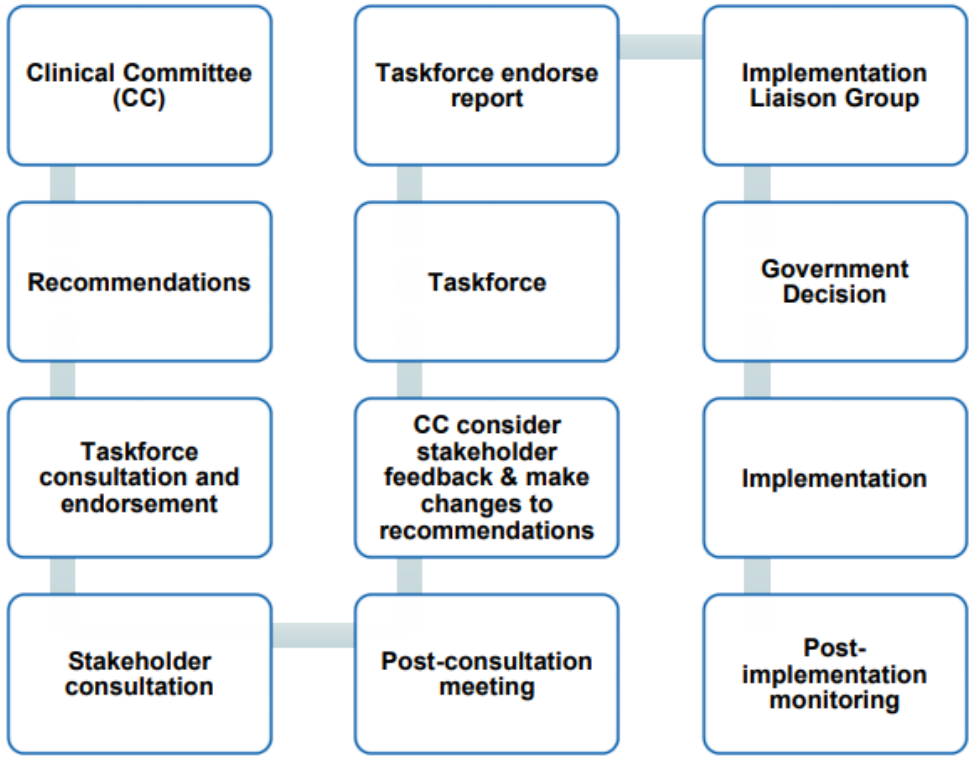
- ✓ Chaired by Professor Bruce Robinson
- ✓ Included over 70 Clinical Committees
- ✓ Informed by over 700 independent clinicians, consumers and health system experts
- ✓ Has reviewed 5,700 MBS items
- ✓ Included over 1300 recommendations



The MBS Review

Reviewing and implementing changes to different MBS specialties, can take up to 3 years:

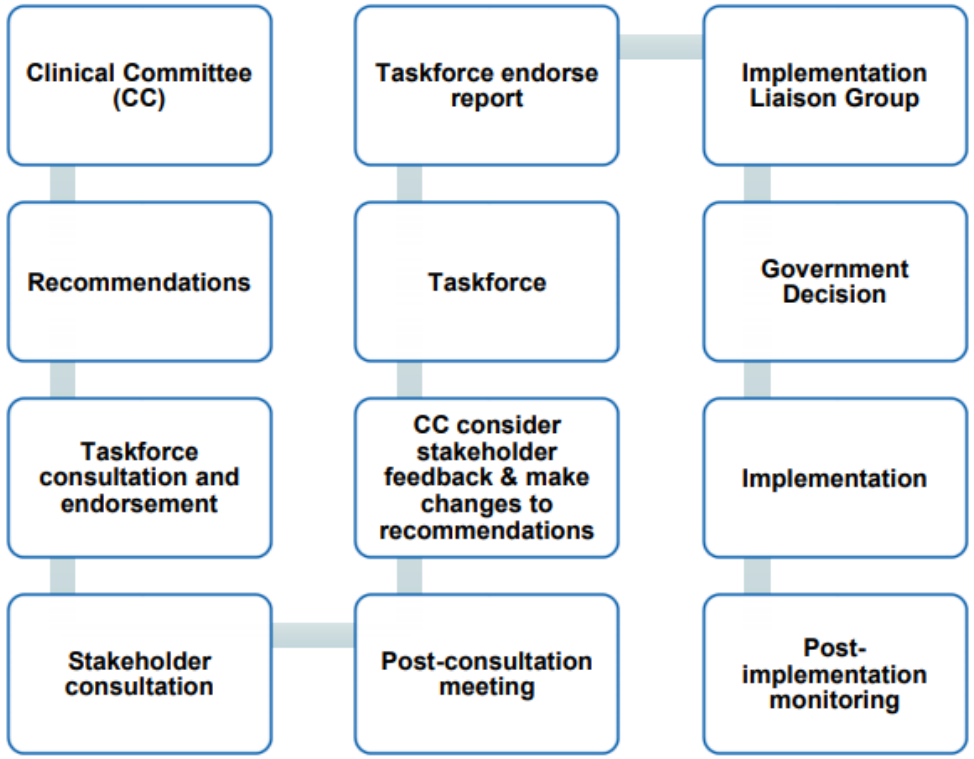
- ✓ To date, the Government has accepted and implemented approximately 350 recommendations changing over 1200 MBS items



The MBS Review

5 Phases of Activity:

- ✓Initial Review
- ✓Consultation
- ✓Consideration by Government
- ✓**Implementation**
- ✓Evaluation



Cardiac Surgical Services Implementation

The Taskforce recommended changes to 189 MBS cardiac services items in 2018. These items included cardiac imaging, coronary artery disease, electrocardiography (ECG), ambulatory electrocardiography and surgical items.

Recommendations, as agreed by Government, are implemented with a two-phased approach:

1. **Phase One –** included changes to cardiac diagnostic imaging items.

   These were implemented on 1 August 2020.

2. **Phase Two –** includes changes to cardiac procedural items and a small number of diagnostic services, which will finalise the remainder of the Taskforce recommendations for MBS cardiac services.

   These changes will be effective from 1 July 2021.

Summary of the Cardiac Procedural Changes

- ✓ 39 New items
- ✓ 59 Deleted items
- ✓ 90 Amended items

Updated on 8 June 2021

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Key recommendations – broad themes

- Create new items as a complete medical service for procedures where currently multiple items are claimed for one procedure
- Update item descriptors to better reflect contemporary best practice
- Incentivise advanced techniques – this includes the creation of new items as “bolt on” items to be claimed in association with primary procedures
- Remove procedures that no longer represent best practice
- Clarifying co-claiming restrictions with surgical procedural items

What does this mean for patients?

Patients will receive Medicare rebates for cardiac procedures that are clinically appropriate and reflect modern clinical practice.

The changes will provide access for patients to high-value cardiac investigations and procedures, leading to improved health outcomes.

Patients should no longer experience significant variances in the Medicare rebates they receive for the same surgical procedures as there should be less variation in the items claimed by different providers.

Patients are less likely to receive unnecessary services.

What does this mean for providers?

FAMILIARISE

Providers will need to familiarise themselves with the new MBS changes and any associated rules and /or explanatory notes.

BILL ACCORDING TO NEW REQUIREMENTS

Providers have a responsibility to ensure that any services they bill to Medicare fully meet the eligibility requirements outlines in the legislation.

KEEP PATIENTS INFORMED

Providers must ensure patients are informed of any associated risks and alternative pathways so they may make informed decisions appropriate to their personal circumstances.

Overview of changes

- Selective Coronary Angiography
- Percutaneous Coronary Intervention (PCI)
- Cardiac valve surgery and coronary artery bypass graft surgery
- Other surgical items
- Implantable devices and electrophysiology studies
- Minor amendments

Over-arching Principles of the MBS

Principle of “complete medical service”

- A complete medical service covers all components required to perform the service described

Claiming subsequent attendance items with items in Group T8 (Items 30001 to 51171 of the MBS)

- There are some subsequent attendance items which can’t be billed on the same day with any Group T8 item equal to or greater than $309.35 (These items include: 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009, 6011, 6013, 6015, 6019, 6052, or 16404)
- You can bill a specialist subsequent attendance (111 or CP item 117 and 120) when :
  - the procedure is urgent and you couldn’t predict the procedure before the start of the attendance, and the services meet the item descriptor

Not being a service associated with

- This restriction prevents the payment of a benefit when the service is performed in association, on the same occasion, with a specific MBS item or item range; another MBS item within the same group or subgroup or a similar type of service or procedure.
- Similar phrases include: “other than a service associated with”; “not in conjunction with item X”;

Over-arching Principles of the MBS

Multiple Operation Rule (MOR) – applies when 2 or more MBS items from Category 3, Group T8 for services performed on a patient on one occasion.

- The total schedule for all surgical items is calculated by applying the MOR. That is:
  - 100% of the fee for the item with the highest schedule fee
  - plus 50% of the fee for the item with the next highest schedule fee
  - plus 25% of the fee for any further surgical items.
- Applying this rule results in one total schedule fee for all surgical items billed.

- (see explanatory note TN.8.2 at MBS Online for more information)

Aftercare – post-operative care and treatment provided to patients after an operation

- MBS fees for most surgical items in MBS Group T8 include aftercare component
- Some MBS services don't include aftercare and this is noted in their description

Selective Coronary Angiography and Percutaneous Coronary Intervention (PCI)

- Restructure of interventional cardiology items and related items.
- New items listed as a complete medical service, simplifying billing to a single item in most cases.
- New items are based on inclusion criteria and complexity.
  - ✓ Following the principles of appropriate use criteria
  - ✓ Inclusion criteria are further grouped into “high risk” patients (Acute -ACS) and “lower risk” patients (Stable)
  - ✓ Inclusion of a Heart Team conference to allow consideration of the “stable” patient who does not meet the inclusion criteria

Selective Coronary Angiography and Percutaneous Coronary Intervention (PCI)

Diagnostic angiography inclusion criteria align with PCI inclusion criteria to allow appropriate progression to intervention when clinically required

If diagnostic angiography has been completed in the previous 3 months there are mirrored items to reflect that a complete diagnostic coronary angiography would may not be required in the provision of the PCI service

Selective Coronary Angiography and Percutaneous Coronary Intervention (PCI)

- Agnostic approach to the procedural intervention performed in PCI
    - allowing multiple approaches within the one item, eg. stent is inserted in isolation or angioplasty with stenting or angioplasty alone, when performed is the provider's choice
- Prosthesis Listing of cardiac stents is unchanged by the MBS changes, private health insurers will be required to pay benefits for products listed on the Prosthesis List (each individual stent), such as cardiac stents, if the stents are provided to the patient with the right cover as part of hospital treatment.

Diagnostic Coronary Angiography– Move to T8

- Current 30000 series and 50000 series angiography items deleted
- Bill a single item as a complete medical service
- Based on inclusion criteria and vessel complexity
- Introduction of:
  - 6 new diagnostic angiography items
  - 1 new item for right heart catheterisation performed with ICA
  - 1 item amended for the use of coronary pressure wire to clarify inclusion criteria

ICA = invasive coronary angiography

Acute Indications

NEW MBS ITEM		MBS FEE	VESSEL COMPLEXITY
38244	Selective Coronary Angiography – native with or without Left heart catheterisation	$920.00	Native
38247	Selective Coronary Angiography – native & graft with or without Left heart catheterisation	$1473.95	Graft

Stable Indications

NEW MBS ITEM		MBS FEE	VESSEL COMPLEXITY
38248	Selective Coronary Angiography – native with or without Left heart catheterisation	$920.00	Native
38249	Selective Coronary Angiography – native & graft with or without Left heart catheterisation	$1473.95	Graft

Pre-Surgery Assessment: Non-Coronary Cardiac Surgery

NEW MBS ITEM		MBS FEE	VESSEL COMPLEXITY
38251	Selective Coronary Angiography – native with or without Left heart catheterisation	$920.00	Native
38252	Selective Coronary Angiography – native & graft with or without Left heart catheterisation	$1473.95	Graft

PCI – Restructure of Items

Based on meeting the clinical indications in the descriptor and the number of territories treated

Vascular territories include:

- Left anterior descending
- Circumflex
- Right coronary artery

Vascular territories refer to the major artery and all its associated branches. The item number claimed should reflect the number of territories stented, with or without angioplasty; or angioplasty alone; not the total number of territories that have undergone intervention to date.

(see Quick Reference Guide and claiming examples for further details of claiming per territory model)

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Angiography Proceeding to PCI (New items)

Invasive Coronary Angiography (ICA) proceeding to PCI where ICA has not been completed in the previous 3 months. The fee includes allowance for the provision of the ICA. The item claimed is dependent on the number of vascular territories stented during the procedure.

CLINICAL INDICATIONS	TERRITORIES	MBS ITEM and FEE
Acute Coronary Syndrome (ACS) • *Meeting the clinical indications in the descriptor*	Single	38307 $1844.60
	Double	38308 $2122.25
	Triple	38310 $2399.90
Non-Acute Coronary Syndrome • *Heart Team conference recommendation; or* • *Meeting the non-ACS clinical indications in the descriptor*	Single	38311^ $1844.60
	Double	38313^ $2122.25
	Triple	38314^ $2399.90

Standalone PCI (New Items)

Performed within 3 months of diagnostic angiography, the fee excludes any allowance for diagnostic angiography

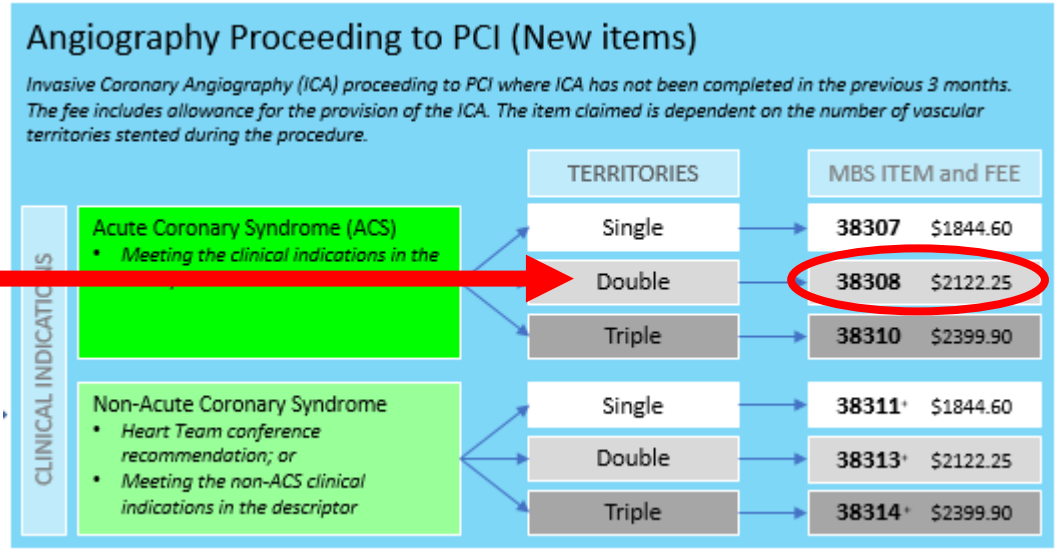
CLINICAL INDICATIONS	TERRITORIES	MBS ITEM and FEE
Acute Coronary Syndrome (ACS) • *Meeting the clinical indications in the descriptor*	Single	38316 $1648.95
	Double	38317 $2088.80
	Triple	38319 $2366.45
Non-Acute Coronary Syndrome (ACS) • *Heart Team conference recommendation; or* • *Meeting the non-ACS clinical indications in the descriptor*	Single	38320^ $1648.95
	Double	38322^ $2088.80
	Triple	38323^ $2366.45

Staging of PCI

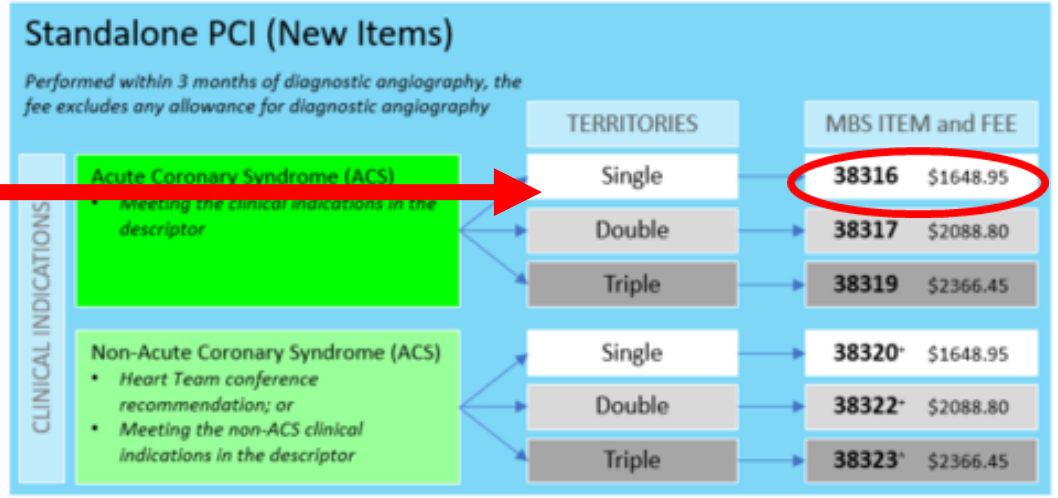
- Appropriate staging of PCI is permissible when clinically appropriate
- The intent of these changes is to incentivise the comprehensive treatment of all applicable lesions in a single service unless the patient's clinical status deems it not appropriate
- If staging is required, the initial stage would be completed under the qualifying indication from the appropriate item and subsequent stages would be conducted using the initial qualifying indication.
- Subsequent stages of a PCI are to be claimed using the items that do not include diagnostic coronary angiography

Example of Staging

Initial stage – completed under qualifying indication from the appropriate item dependent on the number of vascular territories treated (In this example two territories)



Subsequent stage – completed under the standalone PCI items and using the item with equivalent territories treated (ie. one territory in the acute setting)



Computed Tomography of the Coronary Arteries (CTCA) Amend item 57360

- Item 57360 – to be performed on a patient that does not have known coronary artery disease, with no significant cardiac biomarker elevation or ECG changes showing acute ischaemia and is at low to intermediate risk of an acute coronary event.
- This change supports the role of CTCA in excluding coronary artery disease in those patients with significant CAD, that is suspected but has not been identified by first line assessment or investigations.
- A service under 57360 can not be provided to a patient if in the previous 5 years the patient has undergone a service associated 57360 or 57364 and no CAD was detected in that service.

Computed Tomography of the Coronary Arteries (CTCA) New item

- 57364 – new item for specialist investigation of non-coronary artery related indications in the patient undergoing non-coronary cardiac surgery.
- This item can be used as an alternative to ICA for the assessment of bypass graft patency using the indications for the graft ICA items 38247, 38249 and 38252 to determine eligibility

Coronary Artery Bypass Graft surgery (CABG)

Introduction of Single Primary Coronary Artery Bypass Graft Item

Consolidation of items into a single item as a complete medical service.

NEW MBS ITEM		MBS FEE
38502	Coronary artery bypass including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein graft or grafts, including: a) harvesting of left internal mammary artery and vein graft material; or b) harvesting of left internal mammary artery; or c) harvesting vein graft material. Not being a service associated with a service to which items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 apply.	$2,451.55
38510	**NEW** Artery harvesting (other than left internal mammary) for coronary artery bypass where more than one arterial graft are required. Claimed in association with item 38502.	$649.25
38511	**NEW** Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass. Claimed in association with 38502	$624.30
38513	**NEW** Creation of a graft anastomosis (including Y-graft, T-graft and graft to graft extensions) requiring micro-arterial or micro-venous anastomosis using microsurgical techniques. Claimed in association with 38502.	$1,040.55

- CABG items are being restructured to consolidate items into a single item
- The new primary (base) item 38502 is a consolidation of all the superseded CABG items (38497, 38498, 38500, 38501, 38503 and 38504)
- Item 38588 (retrograde administration for cardioplegia) built into the primary procedural item
- Three new items will be available to “add on” with this primary item when additional procedures or technical complexity are required (bolt on items)

Coronary Artery Bypass Graft surgery (CABG)

- Item 38637 has been retained as an add on item and will be amended to clarify claiming restrictions.

- Despite the low service volumes of this item it has been retained to acknowledge added complexity particularly in the re-operation setting.

Add on item:

38637	**AMENDED** Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of. Not being a service associated with a service to which items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 apply.	$571.85

Surgical Valve items – Valve repair items

- Introduction of two new valve items based on the complexity of the repair, recognising that there is significant difference between a two-leaflet repair, which is a more technically complicated procedure than a single leaflet.
- Annuloplasty has been included in the primary valve repair items as it represents best practice, but "with or without option" acknowledging it can be performed at the discretion of the surgeon.
- In recognition that annuloplasty with ring has value as a procedure outside of valve repair it has been retained as a stand alone procedure.

Valve Repair Items: *restructure of items based on complexity*

NEW MBS ITEM		MBS FEE
38516	**NEW** Simple valve repair, with or without annuloplasty, including quadrangular resection, cleft closure, or Alfieri. Including retrograde cardioplegia, where performed. Not being a service associated with a service to which items 38806, 38418, 11704, 11705, 11707, 11714, 45503, 33824 or 18260 apply	$2,451.55
38517	**NEW** Complex valve repair, with or without annuloplasty, involving one of (a) Neochords; or (b) Chordal transfer; or (c) Patch augmentation; or (d) Multiple leaflets. Including retrograde cardioplegia, where performed. Not being a service associated with a service to which items 38806, 38418,311704, 11705, 11707, 11714, 45503, 33824 or 18260 apply	$3,055.85

Stand-alone Procedure:

38477	**AMENDED** Valve annuloplasty with insertion of ring other than a service to which items 38516 or 38517.	$2,065.95

Surgical Valve items – Valve replacement items

- The valve replacement items have been restructured to create complete medical services and rather than items being demarcated by approach they will be listed according to the location of the valve

- A new item is being introduced for the removal of a previously inserted prosthesis during aortic, pulmonary, mitral or tricuspid replacement. Item 38519 specifically allows removal of a previous prosthesis and can only be billed in association with either primary valve replacement item.

Valve Replacement Items: *restructure of items based on location of the valve*

	NEW MBS ITEM	MBS FEE
~~38484~~	NEW Aortic or pulmonary valve replacement with bio-prosthesis or mechanical prosthesis	$2,112.20
~~38499~~	NEW Mitral or tricuspid valve replacement	$2,112.20

Add-on Items:

38519	NEW Valve explant item used in association with items 38484 and 38499	$1,100.00
38490	AMENDED Sub valvular structures used in association with item 38499	$571.85

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Aortic Procedures

- Updated to better define the complexity of modern aortic intervention
- A number of items are retained with little amendment
- A new item (38558) will be introduced for the repair of the aortic arch in a neonate. Co-claiming restrictions prevent claiming of services which would be considered part of the base item.
- Replacement or repair of the aortic arch is being consolidated into two new items for : simple and complex procedures (items 38555 and 38557)

Item 38555 and 38557 are claimable in association with standard thoracic ascending to descending aortic items (38550, 38553, 38554, 38556, 38568 and 38571)

Extraction of Leads (Item 38358)

- Item 38358 provides for the extraction of chronically implanted transvenous or defibrillator leads by an Interventional Cardiologist or Cardiothoracic Surgeon.
- If undertaken by an Interventional Cardiologist, a Cardiothoracic Surgeon must be present during the lead extraction procedure.
- An additional new attendance item (90300) will be introduced.
- If the lead extraction is undertaken by an Interventional Cardiologist, the Cardiothoracic Surgeon can claim item 90300 for the attendance during extraction.
- If the procedure is undertaken by the Cardiothoracic Surgeon then the surgeon will claim the procedural item (38358) *and* the attendance item (90300)

Other Surgical items

Where items are not performed as standalone procedures they have been incorporated into the appropriate items and deleted.

- An example of this- item 38588 cannulation of the coronary sinus will be deleted and incorporated into the appropriate items where cannulation of the coronary sinus is required.

Other Surgical items

Amend items to clarify what items are not appropriate to claim with the procedure

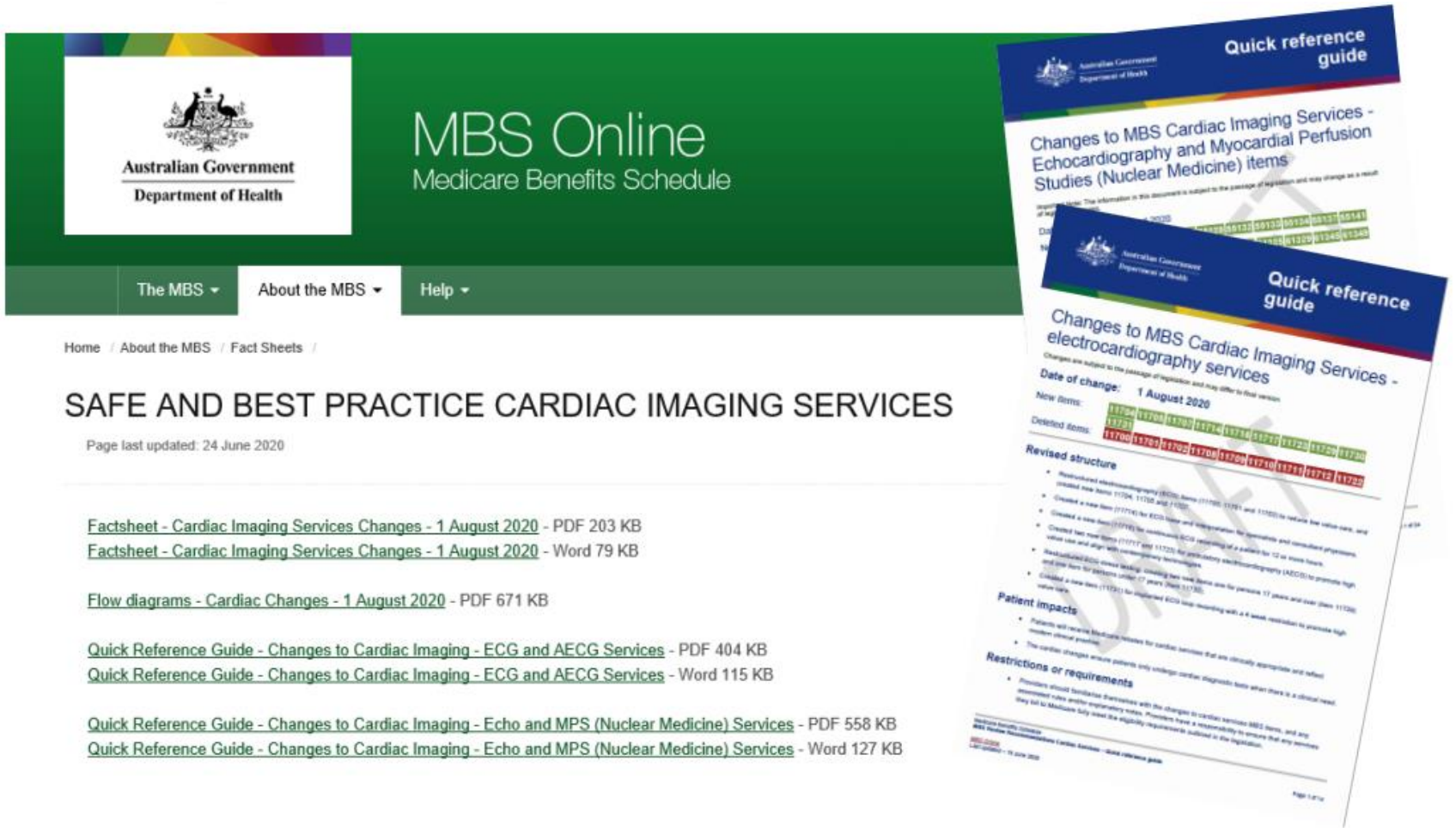
- Restriction to services considered inherent to the primary procedure, such as intercostal drain insertion, intercostal nerve blocks and ECG services.

Other Amendments

- Pacemakers, defibrillators, ECG loop recorders & cardiac resynchronisation devices – changes to align descriptors with current clinical practice guidelines and clarify when electrophysiological testing is included in the service.

- Myocardial Perfusion Studies (MPS) & some echocardiograph items have minor administrative changes

Finding Materials on MBS Online



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[Link to factsheets on MBS Online](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/factsheet-current)
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/factsheet-current

Questions and further information

For questions relating to:

Implementation or the interpretation of the changes to cardiac procedural MBS items prior to 1 July 2021	• email cardiacservices@health.gov.au and title the email *Phase 2 cardiac changes*
Proposed PHI classifications,	• email phi@health.gov.au
Interpretation of the cardiac procedural MBS items after implementation on 1 July 2021	• email askMBS@health.gov.au

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