Australian Government

Medical Services Advisory Committee

MSAC Public Summary Document

Application No. 1159 – Palliative Care Consultation Items

Sponsor/Applicant/s: **Department of Health in consultation with the Australian & New Zealand Society of Palliative Medicine (ANZSPM)**

Date of MSAC consideration: **MSAC 61st Meeting, 3-4 April 2014**

1. Purpose of application

The application was submitted in June 2011 by the Department of Health, in consultation with the Australian & New Zealand Society of Palliative Medicine (ANZSPM) and requested the introduction of new Medicare Benefits Schedule (MBS) items for the assessment and management of complex palliative care patients by a palliative care specialist.

The application also seeks to equitably remunerate doctors who specialise in palliative care through different training pathways i.e. those who are recognised as a consultant physician and those recognised as a specialist.

2. Background

MSAC has not previously considered palliative care consultation items.

There are currently eight palliative medicine professional attendance items (which include two telehealth items) available on the MBS and 12 palliative medicine items for case conferencing.

3. Prerequisites to implementation of any funding advice

The intervention is not required to be TGA approved.

4. Proposal for public funding

Two options for public funding were proposed:

1) Introduction of consultant physician equivalent complex assessment items claimable twice during a single episode of patient care (as opposed to the current initial and subsequent attendance structure); and

2) A restructure of the palliative medicine attendance items to a time tier structure.

MSAC also considered a third option, of introducing complex assessment and review items, available in the hospital/surgery setting, equivalent to existing consultant physician items and complex assessment and review items, available in the home or community setting weighted at a higher fee.

The ANZSPM expressed their support for the third option.

The first option involved:

- One new item at a consultant physician 'referred patient treatment and management planning' rate (132) to be claimable for an ***initial assessment*** in hospital/surgery or as a home visit; AND, one existing 'professional attendance' item for palliative medicine specialists to undertake detailed patient ***reassessment*** in hospital/surgery (3005) or as a home visit (3018);

OR

- Two existing 'professional attendance' items for palliative medicine specialists to undertake an ***initial assessment*** and detailed ***reassessment*** in hospital/surgery (3005) or as a home visit (3018)

AND (with either of the above)

- Retention of all current items relating to subsequent and subsequent minor attendances for hospital/surgery consultation (3010, 3014) or home visits (3023, 3028).

Proposed item descriptors - option 1

PALLIATIVE CARE MEDICINE SPECIALIST, REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL

MBS Item XXXX

Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:

a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and

b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations

Not being an attendance on a patient in respect of whom, an attendance under items 3005, 3010 or 3014 has been received on the same day by the same palliative care medicine specialist. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same palliative care medicine specialist.

Fee: $263.90 Benefit: 75% = $197.95 85% = $224.35

PALLIATIVE CARE MEDICINE SPECIALIST, REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN – OUTSIDE OF SURGERY OR HOSPITAL

MBS Item XXXX

Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:

a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and

b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations

Not being an attendance on a patient in respect of whom, an attendance under items 3018, 3023 or 3028 has been received on the same day by the same palliative care medicine specialist. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same palliative care medicine specialist.

Fee: $263.90 Benefit: 75% = $197.95 85% = $224.35

The second option involved:

- Four ‘time-tiered’ items for detailed assessments, claimable on two separate occasions for any given patient within a 12-month period. This would be similar to a range of current MBS item numbers available to existing specialists (A3) and palliative medicine specialists (A24), but the Schedule fee would be fixed so that it did not exceed the maximum available to other Physicians (A4), and include:

Proposed item descriptors - option 2

Category 1 – Professional attendances

MBS Item YYY1

Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an initial or subsequent assessment of not more than 20 minutes duration.

Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been received under any more than one of YYY1, YYY2, YYY3, or YYY4 for attendance by the same palliative care medicine specialist.

Fee: $88.55 Benefit: 75% = $66.41 85% = $75.27

MBS Item YYY2

Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an initial or subsequent assessment of more than 20 minutes, but not more than 40 minutes duration. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been received under any more than one of YYY1, YYY2, YYY3, or YYY4 for attendance by the same palliative care medicine specialist.

Fee: $150.90 Benefit: 75% = $113.18 85% = $128.27

MBS Item YYY3

Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an initial or subsequent assessment of more than 40 minutes, but not more than 60 minutes duration. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been received under any more than one of YYY1, YYY2, YYY3, or YYY4 for attendance by the same palliative care medicine specialist.

Fee: $207.40 Benefit: 75% = $155.55 85% = $176.29

MBS Item YYY4

Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an initial or subsequent assessment of more than 60 minutes duration.

Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been received under any more than one of YYY1, YYY2, YYY3, or YYY4 for attendance by the same palliative care medicine specialist.

Fee: $263.90 Benefit: 75% = $197.93 85% = $224.32

- Four ‘time-tiered’ items, for subsequent attendances. This would be also similar to a range of current MBS item numbers available to existing Specialists (A3) and palliative medicine specialists (A24) but the Schedule fee would be fixed so that it did not exceed the maximum available to other Physicians (A4) and would include:

Proposed item descriptors - option 2

Category 1 – Professional attendances
MBS Item ZZZ1
Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - a subsequent attendance to an initial or subsequent assessment of not more than 20 minutes duration.
Fee: $43.00 Benefit: 75% = $32.25 85% = $36.55

MBS Item ZZZ2
Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - a subsequent attendance to an initial or subsequent assessment of more than 20 minutes, but not more than 40 minutes duration.
Fee: $75.50 Benefit: 75% = $56.63 85% = $64.18

MBS Item ZZZ3
Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - a subsequent attendance to an initial or subsequent assessment of more than 40 minutes, but not more than 60 minutes duration.
Fee: $103.80 Benefit: 75% = $77.85 85% = $88.23

MBS Item ZZZ4
Professional attendance by an palliative care medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - a subsequent attendance to an initial or subsequent assessment of more than 60 minutes duration.
Fee: $132.10 Benefit: 75% = $99.08 85% = $112.29

Any new time-tiered items would replace current items for initial ‘professional attendance’ in hospital/surgery (3005) or home visit (3018) and for ‘subsequent’ and ‘minor subsequent’ attendances in hospital/surgery (3010 and 3023) or home environments (3018 and 3028).

The third option was the introduction of a new item at a consultant physician ‘referred patient treatment and management planning’ rate (132) to be claimable for an ***initial assessment*** in hospital/surgery, with an additional item at a higher weighted fee for services provided in the home/community, and the introduction of a new item at a consultant physician ‘review of referred patient treatment and management plan’ rate (133) to be claimable for an ***subsequent assessment*** in hospital/surgery, with an additional item at a higher weighted fee for services provided in the home/community.

Proposed item descriptors - option 3

Initial Assessment:

PALLIATIVE CARE MEDICINE SPECIALIST, REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL
MBS Item XXXX
Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:
a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and
b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations
Not being an attendance on a patient in respect of whom, an attendance under items 3005, 3010 or 3014 has been received on the same day by the same palliative care medicine specialist. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same palliative care medicine specialist.
Fee: $263.90 Benefit: 75% = $197.95 85% = $224.35

PALLIATIVE CARE MEDICINE SPECIALIST, REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN – OUTSIDE OF SURGERY OR HOSPITAL
MBS Item XXXX
Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:
a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and
b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations
Not being an attendance on a patient in respect of whom, an attendance under items 3018, 3023 or 3028 has been received on the same day by the same palliative care medicine specialist. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same palliative care medicine specialist.
Fee: $TBA Benefit: 75% = $TBA 85% = $TBA

Subsequent Assessment:

PALLIATIVE CARE MEDICINE SPECIALIST, REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL
MBS Item XXXX
Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for review of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:
a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations; -review of responses to treatment and medication plans and at the time of initial consultation comprehensive multi or detailed single organ system assessment; and
b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment - treatment options and decisions – revised medication recommendations
Not being an attendance on a patient in respect of whom, an attendance under items 3005, 3010 or 3014 has been received on the same day by the same palliative care medicine specialist. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item (xxx) by the same palliative care medicine specialist, payable not more than twice in any 12 month period. The subsequent attendance under item (xxx) is to be provided by either the same palliative care medicine specialist or a locum tenens.
Fee: $132.10 Benefit: 75% = $99.10 85% = $112.30

PALLIATIVE CARE MEDICINE SPECIALIST, REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - OUTSIDE OF SURGERY OR HOSPITAL
MBS Item XXXX
Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for review of a patient with at least two morbidities, where the patient is referred by a referring practitioner, and where:
a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations; -review of responses to treatment and medication plans and at the time of initial consultation comprehensive multi or detailed single organ system assessment; and
b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment - treatment options and decisions – revised medication recommendations
Not being an attendance on a patient in respect of whom, an attendance under items 3005, 3010 or 3014 has been received on the same day by the same palliative care medicine specialist. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item (xxx) by the same palliative care medicine specialist, payable not more than twice in any 12 month period. The subsequent attendance under item (xxx) is to be provided by either the same palliative care medicine specialist or a locum tenens.
Fee: $TBA Benefit: 75% = $TBA 85% = $TBA

5. Summary of Consumer/Consultant Feedback

MSAC's Protocol Advisory Sub-Committee (PASC) of MSAC noted that the comments received from ANZSPM during the public consultation period on the DAP were generally not supportive of the time-tiered items that had been proposed by the Department and instead reiterated the ANZSPM's position that its preference was for the addition of items that are similar to MBS Items 132 and 133 (option 1).

PASC considered that, given the poor health status of patients requiring palliative services, it was appropriate that differential MBS palliative medicine items should be available for delivery of medical services in settings other than the consulting rooms or hospital setting (e.g. to include nursing home, hospice or the patient's own home).

The Consumers Health Forum (CHF) was concerned that the proposed 'new' items are not sufficiently different from existing MBS services and therefore the main outcome of the proposed MBS items will be a change in remuneration to palliative medicine specialists, rather than an improvement in the way services are currently delivered.

6. Proposed intervention's place in clinical management

The clinical algorithm was equivalent to other specialty areas, where the majority of patients are managed in general practice, and acute or complex patients are referred for specialist consultation and/or ongoing management, as appropriate.

The MBS listing would outline the services that are expected to be delivered in the preparation of a complex treatment and management plan.

7. Comparator

The most clinically acceptable and cost-effective comparison for investigation involves the referral and management of palliative care patients in the community rather than an admitted hospital environment.

MSAC considered that this application was difficult to assess using a traditional health technology assessment format, (including the identification of comparators) as the usual trial-based evidence to inform the assessment was not available.

8. Comparative safety

Systematic analysis of the specific safety associated with delivery of pharmacotherapy interventions provided by palliative care specialists (compared with delivery by other specialist groups) is lacking in the research literature.

Comparisons with palliative care provided in general practice indicate that palliative care specialists are able to maintain a higher level of skill across a wide range of patients with palliative care needs.

Thus, from the available evidence, services provided by palliative medicine specialists are possibly safer and more effective than the same services provided across a range of different medical practitioners.

MSAC noted that there are no studies available on the effectiveness of palliative care specialist medical interventions, systematic analysis of the safety associated with delivery of these interventions (compared with delivery by other specialist group) or the effect of the interventions on patient outcomes.

9. Comparative effectiveness

Given the multi-disciplinary nature of palliative care, research has not specifically examined the role of palliative medicine specialists as an individual component of team based interventions.

The available evidence indicated that specialists in palliative medicine are more likely to provide, or otherwise co-ordinate, the best mix of evidence-based interventions in the right environment, to maximise patient and carer quality of life.

There is no evidence that the outcomes of interventions provided by palliative medicine specialists will be any worse than the same interventions provided by other specialists.

MSAC noted that there was no evidence provided to suggest that the outcomes of interventions provided by palliative care specialists will be any worse than the same interventions provided by other specialists and that there is no unmet need in relation to this proposal. MSAC accepted that all palliative care specialists undergo equivalent training regardless of whether they are consultant physicians or not and that all services provided by palliative care specialists would be equivalent.

10. Economic evaluation

The application presented a cost effectiveness analysis.

The economic evaluation of the palliative medicine MBS items was based on a relative cost of medical consultations in hospitals versus the community.

A modelled comparative analysis of current costs as at 2012-13 by palliative medicine (and other unknown) specialists working in the community rather than a hospital environment was developed.

The forecast costs for palliative medicine were based on the proposed fee structure where assessment and patient review are at physician rates.

The forecast MBS outlays using community treatment to divert potentially preventable hospital admissions was an additional outlay of up to approximately $5 million, to achieve a potential notional savings to the health system of approximately $21 million.

The application suggested that even with an increase in payment rates for palliative medicine specialists, a significant cost advantage may be realised if an increase in the number of community palliative specialist consultations can be achieved. However, these figures cannot be verified.

To assist MBS sustainability into the future, Extended Medicare Safety Net capping is proposed for all of the new palliative medicine items, in line with current policy for all MBS professional attendances (e.g. at a rate of 300% of the MBS fee, or lower).

MSAC considered that if there were more community-based palliative care deaths then this could potentially be cost saving but there is no evidence to support that changing the MBS item numbers for palliative care specialists would increase the number of deaths in the community setting.

11. Financial/budgetary impacts

It was estimated that a total of 76,124 occasions of MBS billed service are currently provided per annum (2013) for palliative medicine. The overall average ratio of initial to subsequent attendances is 1 initial to 4.76 subsequent services in an admitted hospital context, and 1 initial to 1.46 subsequent services in a community context. However, these crude ratios mask a variety of models of care ranging from regular (monthly) pharmacotherapy treatments to single event assessment on a GP referral.

The assessment report claimed that palliative medicine is more cost effective when engaged in the community setting as it prevents potentially avoidable (and more expensive) hospital admissions associated with end of life care. The assessment report claimed that the proposed options would increase the volume of services currently provided in the community/home setting. There is limited evidence available to support this and the consequential modelling that an introduction of such items could result in a potential notional save to the health system of $21 million per annum.

The current (2012/13) MBS outlays for palliative medicine are estimated to be approximately $5.8 million. However, due to service number increases and indexation, it is estimated that this will rise to $7.18 million by 2014/15.

The Department estimated that the increases in MBS expenditure associated with each of the options would be as follows:

Option 1 – Consultant physician equivalent initial assessment items

Year 1 MBS $ (2014-15)	Year 2 MBS $ (2015-16)	Year 3 MBS $ (2016-17)	Year 4 MBS $ (2017-18)	**4 year total MBS $**
$1.5 million	$3.6 million	$3.9 million	$4.3 million	**$13.4 million**

Option 2 – Time-tiered items

Year 1 MBS $ (2014-15)	Year 2 MBS $ (2015-16)	Year 3 MBS $ (2016-17)	Year 4 MBS $ (2017-18)	**4 year total MBS $**
$1.6 million	$3.7 million	$4.0 million	$4.4 million	**$13.7 million**

Option 3 – Consultant physician equivalent initial and subsequent assessment items

Year 1 MBS $ (2014-15)	Year 2 MBS $ (2015-16)	Year 3 MBS $ (2016-17)	Year 4 MBS $ (2017-18)	**4 year total MBS $**
$1.5 million	$3.6 million	$3.9 million	$4.3 million	**$13.4 million**

MSAC noted that there was little evidence to support the application estimated cost savings to the health system of $21 million per year with introduction of the new MBS items.

12. Other significant factors

Nil

13. Summary of consideration and rationale for MSAC's advice

MSAC noted the training pathways for palliative care specialists differ. All palliative care specialists undergo a three year training program. However, some specialists are already consultant physician qualified and are therefore able to access higher rebated consultant physician MBS items, different from their palliative care specialist colleagues.

The application claimed that palliative care management plans have become more complex since the introduction of MBS items for palliative care consultations in 2006 and that introduction of new items on the MBS schedule for complex consultations will better support complex patient assessment and review and equitably remunerate all doctors who specialise in palliative care.

MSAC considered that this application was difficult to assess using a traditional health technology assessment format as the usual trial-based evidence to inform the assessment is not available. No studies are available on the effectiveness of palliative care specialist medical interventions, systematic analysis of the safety associated with delivery of these interventions (compared with delivery by other specialist group) or the effect of the interventions on patient outcomes.

Limited evidence was provided for end of life care and the role of the palliative care specialist in the referral and management of these patients in the community rather than admitting them to hospital. Studies show that the majority of patients, with the support of their carers, prefer to die in a community setting. The application claimed that whilst palliative care admissions to hospital cannot always be avoided, there is a cohort of

individuals who may avoid hospital admission by receiving appropriate community based management and therefore increase the volume of services in the community setting.

Data from the Australian Institute of Health and Welfare (AIHW) on the number of private hospital palliative care separations (2006-2015) was somewhat supportive as it predicted that, of all the states, Western Australia (WA) would continue to experience low and declining hospital separations. This could be due to the focus in WA on community-based palliative care service delivery. However, the Committee also noted that this could be influenced by an up skilled GP workforce, nursing and allied health palliative care team particularly as WA has the lowest rate of specialists per 100,000 population.

MSAC considered that if there were more community-based palliative care deaths then this could potentially be cost saving but there is no evidence to support that changing the MBS item numbers for palliative care specialists will increase the number of deaths in the community setting. MSAC acknowledged the valuable contribution of the palliative care specialists but was not convinced by the very limited evidence that introduction of new complex assessment and treatment items for palliative medicine specialists will have a significant effect on changing the model of care.

MSAC noted that there was no evidence provided to suggest that the outcomes of interventions provided by palliative care specialists will be any worse than the same interventions provided by other specialists and that there is currently no unmet need in relation to this proposal. MSAC accepted that all palliative care specialists undergo equivalent training regardless of whether they are consultant physicians or not and that all services provided by palliative care specialists would be equivalent.

MSAC noted that there was little evidence to support the application estimated cost savings to the health system of $21 million per year with introduction of the new MBS items. The Department estimates were for MBS costs of approximately $4 million per year.

Overall, MSAC considered that making multiple individual adjustments to consultation items without an overall review of the policy structure may add complexity and potential inconsistencies to the MBS.

MSAC noted that two telehealth items specific to palliative care specialists were added to the MBS in January 2013 (items 3003 and 3015).

MSAC supported the application’s proposal that the current MBS items for palliative care specialists be modified to make explicit their application to a range of community settings (e.g., home visits, residential aged care visits, hospice visits).

14. MSAC's advice to the Minister

After considering the strength of the available evidence in relation to the safety, clinical effectiveness and cost-effectiveness of palliative care medicine consultation items MSAC considered that there was a lack of evidence to support the claim and that the nature of the application itself was outside MSAC's normal frame for consideration.

MSAC, however, noted that there may be some benefit in the introduction of new complex assessment and treatment items for palliative medicine specialists and referred the matter back to the Department.

15. Applicant's comments on MSAC's Public Summary Document

ANZSPM believes there are several high quality trials that demonstrate palliative medicine specialist outpatient & community consultant involvement leads to improved quality of life, improved survival, reduced health care costs, decreased hospital admissions and reduced emergency department visits for palliative care patients (Refer *ANZSPM Comment on MSAC Public Summary Document: Palliative Medicine Specialist Outpatient and Community Consultancy leads to Improved Quality of Life (May 2014)* http://www.anzspm.org.au/c/anzspm?a=da&did=1005077&pid=1320267688

It further believes that changes to MBS item numbers as detailed in their submission, will increase access to and involvement of Palliative Medicine Specialists, and will lead to health care improvements as detailed above.

16. Linkages to other documents

Further information is available on the MSAC Website at: www.msac.gov.au.