



Australian Government

Medical Services Advisory Committee

MSAC Public Summary Document

Application No. 1170 – Intensive Care Medicine Consultation Items

Sponsor/Applicant/s: Department of Health in consultation
with the Australian & New Zealand
Intensive Care Society (ANZICS)

Date of MSAC consideration: 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 Intensive Care Society (ANZICS) and requested the introduction of new Medicare Benefits Schedule (MBS) items for consultations undertaken by intensive care medicine (ICM) specialists outside of an intensive care unit (ICU).

The purpose for the proposed service is to provide early expert advice on the best course of treatment to a patient who is seriously ill.

2. Background

MSAC has not previously considered intensive care consultation items.

The MBS has no professional attendance items specifically intended for ICM specialists for provision of services outside the ICU.

3. Prerequisites to implementation of any funding advice

The intervention is not required to be TGA approved.

No other specific services are required to be administered prior to, with or following the requested medical service. However, follow-up services may need to be rendered following a consultation with an ICM specialist. For example, pathology tests and diagnostic imaging services for assessment of a patient's status and therapeutic services (including medications) during a consultation.

4. Proposal for public funding

The application presented the following three options for new MBS items:

- 1) the introduction of consultant-physician-equivalent initial and subsequent attendance items which are time-tiered and which exclude any item/s for complex assessment and treatment planning in the ward (but long attendance items – 60 minutes plus – are included in the top time tier item);
- 2) the introduction of consultant-physician-equivalent initial and subsequent attendance items which are not time-tiered and which exclude any item/s for complex assessment and treatment planning in the ward; and
- 3) the introduction of consultant-physician-equivalent initial and subsequent attendance items which are not time-tiered and which include an item for complex assessment and treatment planning in the ward.

The proposed MBS items for each of these three options were as follows:

Option 1 - for time-tiered initial and subsequent attendance items

Initial attendance MBS items

Category 1 – Professional attendances

MBS Item YYY1

Professional attendance by an intensive 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 assessment of not more than 20 minutes** duration.

Not being an attendance on a patient in respect of whom, an attendance under item **13870** has been received on the same day **by any intensive care medicine specialist**.

Not being an attendance on the patient in respect of whom, **during the same admitted patient episode**, payment has been made under **items YYY1, YYY2, YYY3, or YYY4** for attendance **by any intensive care medicine specialist**.

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

MBS Item YYY2

Professional attendance by an intensive 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 assessment of more than 20 minutes, but not more than 40 minutes** duration.

Not being an attendance on a patient in respect of whom, an attendance under item **13870** has been received on the same day **by any intensive care medicine specialist**.

Not being an attendance on the patient in respect of whom, **during the same admitted patient episode**, payment has been made under **items YYY1, YYY2, YYY3, or YYY4** for attendance **by any intensive care medicine specialist**.

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

MBS Item YYY3

Professional attendance by an intensive 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 assessment of more than 40 minutes, but not more than 60 minutes** duration.

Not being an attendance on a patient in respect of whom, an attendance under item **13870** has been received on the same day **by any intensive care medicine specialist**.

Not being an attendance on the patient in respect of whom, **during the same admitted patient episode**, payment has been made under **items YYY1, YYY2, YYY3, or YYY4** for attendance **by any intensive care medicine specialist**.

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

MBS Item YYY4

Professional attendance by an intensive 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 assessment of more than 60 minutes** duration.

Not being an attendance on a patient in respect of whom, an attendance under item **13870** has been received on the same day **by any intensive care medicine specialist**.

Not being an attendance on the patient in respect of whom, **during the same admitted patient episode**, payment has been made under **items YYY1, YYY2, YYY3, or YYY4** for attendance **by any intensive care medicine specialist**.

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

Subsequent attendance MBS items

Category 1 – Professional attendances

MBS Item ZZZ1

Professional attendance by an intensive 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 assessment by any intensive care medicine specialist during the same admitted patient episode, of not more than 20 minutes duration.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$43.00 Benefit: 75% = \$32.25 85% = \$36.55

MBS Item ZZZ2

Professional attendance by an intensive 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 assessment by any intensive care medicine specialist during the same admitted patient episode, of more than 20 minutes, but not more than 40 minutes duration.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$75.50 Benefit: 75% = \$56.63 85% = \$64.18

MBS Item ZZZ3

Professional attendance by an intensive 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 assessment by any intensive care medicine specialist during the same admitted patient episode, of more than 40 minutes, but not more than 60 minutes duration.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$103.80 Benefit: 75% = \$77.85 85% = \$88.23

MBS Item ZZZ4

Professional attendance by an intensive 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 assessment by any intensive care medicine specialist during the same admitted patient episode, of more than 60 minutes duration.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$132.10 Benefit: 75% = \$99.08 85% = \$112.29

Option 2 - Standard initial and subsequent consultations

INTENSIVE CARE MEDICINE SPECIALIST, INITIAL ATTENDANCE

MBS Item ZZZ1

Professional attendance by intensive care medicine specialist in his or her specialty, where the patient is referred to him or her by a referring medical practitioner.

Detailed assessment provided once in a single course of treatment, provided at any point during that course of treatment.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Not being an attendance on the patient in respect of whom, during the same admitted patient episode, payment has been made under this item for attendance by any intensive care medicine specialist.

Fee: %150.90 Benefit: 75% = \$113.20 85% = \$128.30

INTENSIVE CARE MEDICINE SPECIALIST, SUBSEQUENT ATTENDANCE

MBS Item ZZZ2

A subsequent attendance following any detailed assessment by any intensive care specialist during the same admitted patient episode under item ZZZ1, by any intensive care medicine specialist.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$75.50 Benefit: 75% = \$56.65 85% = \$64.20

Option 3 - Option 2 plus the following items allowing for complex treatment Planning

INTENSIVE CARE MEDICINE SPECIALIST, INITIAL ATTENDANCE

MBS Item XXX1

Professional attendance by intensive care medicine specialist in his or her specialty, where the patient is referred to him or her by a referring medical practitioner.

Detailed assessment provided once in a single course of treatment, provided at any point during that course of treatment. Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Not being an attendance on the patient in respect of whom, during the same admitted patient episode, payment has been made under this item for attendance by any intensive care medicine specialist.

Fee: %150.90 Benefit: 75% = \$113.20 85% = \$128.30

INTENSIVE CARE MEDICINE SPECIALIST, REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN – SURGERY OR HOSPITAL

MBS Item XXX2

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;
- a comprehensive multi or detailed single organ system assessment;
- the formulation of a 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; and
- medication recommendations;

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Not being an attendance on the patient in respect of whom, during the same admitted patient episode, payment has been made under this item for attendance by any intensive care medicine specialist.

Fee: \$263.90 Benefit: 75% = \$197.95 85% = \$124.35

INTENSIVE CARE MEDICINE SPECIALIST, SUBSEQUENT ATTENDANCE

MBS Item XXX3

A subsequent attendance following any detailed assessment by any intensive care specialist during the same admitted patient episode under items XXX1 or XXX2, by any intensive care medicine specialist.

Not being an attendance on a patient in respect of whom, an attendance under item 13870 has been received on the same day by any intensive care medicine specialist.

Fee: \$75.50 Benefit: 75% = \$56.65 85% = \$64.20

5. Summary of Consumer/Consultant Feedback

The MSAC's Protocol Advisory Sub-Committee noted that the Australian Medical Association (AMA) did not support the proposed listing of four-time based professional attendance (consultation) items, as this is not what the speciality applied for. The AMA noted that, depending on the final MBS fee, time-based items can distort the provision of medical services. The AMA further noted that time-tiered services are unlikely to reflect the current clinical practice of intensive care medicine.

6. Proposed intervention's place in clinical management

Patients requiring the attendance of an ICM specialist will include people of all ages who suffer from various medical conditions. There is no specific disease or medical condition that defines the patient population.

The application indicated that the clinical place for professional attendance by an ICM specialist occurs at the point at which a patient's specialist team or an emergency department physician makes a clinical judgement that such an attendance is necessary to determine the appropriate course of therapeutic intervention. The new services are variations of existing billed services but paid at a different and higher fee.

7. Comparator

The application stated that the most immediate comparator to the proposed new MBS items is existing arrangements, whereby around one third of intensive care specialists continue to claim physician equivalent (A4) items, and the remaining two thirds of specialists can only claim for items listed on the A3 schedule.

In the absence of intensive care medicine specialists performing out-of-ICU consultations, interventions would be provided by a range of different specialists.

The most clinically comparable model of care for the majority of current Medical Emergency Team (MET) or Rapid Response Team (RRT) systems operating in public and private hospitals would be the two-tiered systems of clinical response operating in a small number of public hospitals. These models of care place initial responsibility for notification and response to clinical deterioration upon the parent medical unit consultant or delegate prior to calling in an intensive care specialist as part of a MET/RRT response.

MSAC considered the MET/RRT model to be a reasonable basis for supporting consultation services out-of-ICU but questioned the cost effectiveness of the evidence presented.

8. Comparative safety

The systematic analysis of the specific patient safety associated with delivery of early ward-based interventions by ICM specialists (compared with delivery by other specialist groups) is lacking in the research literature.

The application stated that services provided by ICM specialists are possibly safer and more effective than the same services provided across a range of different medical practitioners working in hospitals. This has not been definitively determined.

9. Comparative effectiveness

The application stated that the available evidence indicated that ICM specialists are more likely to provide benefit to patient recovery and/or quality of life. However, the application did not include evidence comparing one specialist type with another specialist type in the overall delivery of care.

The application noted that interventions with METs are effective and have a positive impact on patient mortality and cardiac arrest rates. The application cited level III and IV evidence that METs have been shown to be associated with reductions in the rate of cardiac arrest (RRR across cited studies: 0 – 65%) and unplanned ICU admissions (RRR across cited studies: 0 – 44%).

The Evaluation Sub-Committee (ESC) noted that the more appropriate (if hypothetical) comparison here is a ‘world with METs’ versus a ‘world without METs’.

MSAC acknowledged the effectiveness of METs in reducing the rates of cardiac arrests and un-planned ICU admissions and the role ICU specialists play in these teams, but noted that there is a lack of evidence of patient outcomes as a result of an out-of-ICU consultation service.

10. Economic evaluation

No economic evaluation was undertaken and therefore the relative impact of any additional expenditure associated with MBS funding for out-of-ICU services cannot be determined.

In order to assist MBS sustainability into the future, Extended Medicare Safety Net capping is proposed for all of the new ICM 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 acknowledged that the cost effectiveness evidence was weak regarding absolute measures of demand and supply.

11. Financial/budgetary impacts

It was estimated that a total of 78,193 occasions of MBS billed services are currently provided as professional attendances per annum (2013) for intensive care medicine.

Modelling undertaken by the Health Technology Assessment group and the Department assumed that any of the options are only likely to be used by intensive care specialists who are not co-registered on the MBS as physicians. Accordingly, assumptions for the modelling of financial impacts associated with each scenario focused upon shifts in MBS claims for specialists currently billing MBS items 104/105; and, the inclusion of an additional 25% of specialists who may have future access to out-of-ICU billing arrangements.

New MBS service volumes estimated by the Department – Consistent across all options

Year 1 services (2014-15)	Year 2 services (2015-16)	Year 3 services (2016-17)	Year 4 services (2017-18)	4 year total services
1,312	3,330	3,484	3,639	11,765

The current (2012/13) MBS outlays for professional attendances billed by registered intensive care medicine specialists are estimated to be approximately \$5.82 million. However, due to service number increases and indexation, it is estimated that this would rise to approximately \$6.58 million by 2014/15.

The Department estimated that the increases in MBS expenditure associated with each of the three Options will be as follows:

New MBS expenditure estimated by the Department

Option 1 – 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 \$
\$0.2 million	\$0.4 million	\$0.4 million	\$0.5 million	\$1.4 million

Option 1 – Consultant physician equivalent attendance 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 \$
\$0.3 million	\$0.8 million	\$0.8 million	\$0.9 million	\$2.8 million

Option 2 – Consultant physician equivalent attendance and complex 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 \$
\$0.4 million	\$0.9 million	\$0.9 million	\$1.0 million	\$3.1million

12. Other significant factors

Nil

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

MSAC noted that the application for the introduction of new Intensive Care Medicine (ICM) specialist items on the Medicare Benefits Schedule (MBS) represented an extension of existing ICM specialist MBS items, to accommodate additional consultation services requested outside of an intensive care unit (ICU) by a range of medical and surgical units.

MSAC noted the training pathways for intensive care specialists differ. All intensive 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 other intensive care specialist colleagues. The application’s primary claim for a revised item structure was to provide for A4 equivalent access for all ICM specialists.

MSAC noted the limited evidence base and the absence of an economic evaluation (due to limited availability of data) in the application. The application focussed predominantly on defining the scope of services provided by medical emergency teams (MET), current utilisation of existing MBS items and workforce issues. MSAC noted that the application acknowledged that definitive cost effective evidence was weak regarding absolute measures of demand and supply. MSAC agreed that the application was difficult to assess using a traditional health technology assessment format and that only limited comparison was possible with two-stage referral of patients to MET teams.

Based on the evidence presented, MSAC agreed that MET are effective in reducing the rates of cardiac arrest and unplanned ICU admissions. MSAC acknowledged that ICM specialists are an integral part of these teams. However, MSAC noted that there is no evidence of improvements in health outcomes from patient access to ICM specialist consultation services outside the ICU compared with alternative models of care. MSAC also noted that there was no evidence provided to suggest that the outcomes of consultations provided by ICM specialists will be any worse than the same consultations provided by other specialists; and that there is currently no unmet need in relation to this proposal.

MSAC acknowledged that intensive care physicians may integrate some management of complex high intensity patients with multisystem issues on the ward as this may sometimes be beyond the abilities of the junior medical staff. However, involvement in complex care planning outside the intensive care unit would be unusual. MSAC discussed the appropriateness of a proposal for time-based items noting that the applicant did not prefer this option. MSAC considered that the current MBS items (A3 and A4 consultation services) encompassed the overall practice scope of ICM specialists. However, MSAC noted that many ICM consultations could be less than 15 minutes and considered that potentially a short attendance MBS item for ward attendance of an intensive care medicine specialist, primarily for the purpose of medical emergency team (MET) calls, at an appropriate fee could be feasible.

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.

14. MSAC's advice to the Minister

After considering the strength of the available evidence in relation to the Intensive Care Medicine consultation items, MSAC considered that the clinical and cost effective evidence presented was not sufficient to support a recommendation on the introduction of revised assessment and treatment items for intensive care medicine specialists and referred the matter back to the Department.

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

No comment.

16. Linkages to other documents

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