



Australian Government

Medical Services Advisory Committee

Public Summary Document

Application No. 1243: The removal of superficial embedded corneal foreign bodies by an optometrist

Applicant: Optometrists Association of Australia

Date of MSAC consideration: MSAC 62nd Meeting, 26-28 November 2014

Context for decision: MSAC makes its advice in accordance with its Terms of Reference, see at www.msac.gov.au

1. Purpose of application and links to other applications

An application requesting MBS listing of removal of a superficial embedded corneal foreign body (CFB) for any person presenting to an optometrist was received from the then Optometrists Association of Australia (now Optometry Australia) by the Department of Health in February 2011.

The application related to a new MBS item by which optometrists may bill for the service described.

2. MSAC's advice to the Minister

MSAC supported public funding of a new MBS item for removal of superficial embedded corneal foreign bodies by optometrists.

MSAC considered that there should be one new MBS item for removal only, with the proposed MBS fee equivalent to that for removal performed by GPs as there was no evidence to support an increased fee for this service.

MSAC requested the Department discuss the proposed MBS item descriptor with the two relevant professional bodies to ensure appropriate use of the proposed MBS item by potentially limiting access to therapeutically endorsed optometrists and the consequence of limiting the service to require performance with a slit lamp.

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

MSAC noted this application seeks MBS funding for the removal of superficial embedded corneal foreign bodies (CFB) by an optometrist. MSAC noted the existing MBS item 42644 covers services provided by general practitioners (GPs) and ophthalmologists but not

optometrists. Current MBS practice requires optometrists to make an MBS claim under standard time-based attendance items.

An embedded CFB is an object, usually metal, that has entered and lodged in the cornea. An embedded CFB requires urgent removal. Superficial embedded CFB that are located away from the visual axis can be removed by an optometrist, GP or emergency department doctor. Centrally located, deeply embedded or penetrating CFB should be removed by an ophthalmologist.

MSAC considered the safety, effectiveness and cost-effectiveness of implementing a new reimbursement item for superficial embedded CFB removal by optometrists. The clinical claim is that removal of a superficial embedded CFB by an optometrist is non-inferior to removal by a GP or ophthalmologist. MSAC noted there is no available scientific evidence supporting this. However, MSAC agreed with its ESC that the claim made by the applicant was reasonable in that the removal of a superficially embedded CFB outside the visual axis is relatively low risk and removal by appropriately trained optometrists is likely to be safe. An economic evaluation was not required for this submission as safety and efficacy are not likely to be effected by the introduction of a new MBS item. MSAC noted that optometrists already provide this service and the request is regarding parity of reimbursement with GPs and ophthalmologists.

MSAC noted uncertainty around the incidence of superficial embedded CFB injuries in Australia. Medicare statistics for billing of item 42644 shows this item was claimed a total of 26,457 times in 2010 – 2011. However, billing of this item is unlikely to be a true reflection of incidence of superficial embedded CFB as patients have several treatment options, including emergency departments and optometrists. MSAC noted the applicant suggestion that optometrists currently perform CFB removal about 10 times per year, meaning an additional 35,000 CFB removal procedures a year are performed by optometrists. As optometrists currently perform CFB removal under non-specific items it is difficult to estimate the actual number of procedures performed annually.

MSAC noted that the introduction of a new item number would probably increase the cost to the MBS and may reduce out of pocket costs for patients. In addition, as this is an accidental injury that is declining in incidence due to occupational health and safety measures, an increase in claims is unlikely.

The applicant proposed a fee of \$90.25 based on direct and indirect practice costs. However, MSAC agreed with advice from its ESC that this fee should be reduced to \$72.15 to align with the fee charged by the same service when performed by GPs and ophthalmologists. There was no evidence presented to justify an increased MBS fee. The proposed incremental costs to the MBS per annum range from \$900,000 to \$2.6 million.

MSAC considered the need to limit the item to optometrists who are therapeutically endorsed, and therefore specifically trained to perform CFB removal procedures. MSAC noted that from 2014 all new optometrists would be therapeutically endorsed and that CFB removal is an established part of the scope of practice of optometrists. MSAC asked that the Department negotiate with the relevant professional bodies regarding the necessity to specifically limit the proposed item to therapeutically endorsed optometrists.

In addition, MSAC considered the proposal to require that optometrists performing CFB removal use a slit lamp, which is more effective where there is a requirement to remove a rust ring as a result of a metallic CFB. MSAC noted this may limit access to CFB removal and

mentioned that, while the use of a slit lamp was probably standard practice, many optometrists may successfully perform CFB removal without the use of a lamp or with a loupe. MSAC asked that the Department negotiate with the relevant professional bodies regarding the necessity to restrict the item to use of slit lamp.

4. Background

MSAC has not previously considered a new MBS item for billing by optometrists to perform a procedure to remove a superficial embedded CFB.

Under current arrangements billing occurs under MBS item number 42644 for provision of the service by general practitioners and ophthalmologists, or alternatively the service is provided by hospital emergency departments. The applicant stated that optometrists currently perform the removal of superficial embedded CFBs (using items 10900, 10913 and 10916), and that the introduction of a new MBS item is unlikely to change practice to any large degree, but will allow optometrists to be reimbursed appropriately.

5. Prerequisites to implementation of any funding advice

The proposed changes to provision of the service would fall under the current regulatory requirements for accreditation and training of optometrists. In order to practice optometry in Australia, it is a requirement that registration is first obtained from the Optometry Board of Australia (OBA) unless otherwise registered as a medical practitioner.

6. Proposal for public funding

The application proposed MBS item descriptor for removal of CFB by optometrists is shown below in Table 1. The wording of the proposed item is based on MBS item 42644, for removal of CFB by an ophthalmologist (with the omission of the word 'sclera'). Should the proposed MBS item be approved, the Department of Health recommended that additional explanatory notes be added to para O6 of the Medicare Benefits Schedule Book Optometrical Services Schedule, as shown in Table 1.

A fee of \$90.25 was proposed by the applicant, based on direct and indirect practice costs and modelling data. The fee was proposed to cover the procedure, which could be claimed as a stand-alone item, or could be used in conjunction with consultation items. PASC and ESC recommended the proposed fee of \$90.25 be reduced to \$72.15 in alignment with the fee charged by the same service when performed by GPs and ophthalmologists (Table 1). This fee may be able to be charged alongside consultation items 10900, 10913 or 10916, as appropriate.

PASC proposed the following item descriptor:

Table 1: Proposed MBS item descriptor for removal of CFB by optometrist

Group A10 – OPTOMETRIC SERVICES
<p>MBS item [xxxxx]</p> <p>CORNEA, removal of embedded foreign body from – not more than once on the same day by the same practitioner (excluding aftercare).</p> <p>Fee: \$72.15 85% = \$61.33</p> <p>For the purpose of item [xxxxx], an embedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.</p> <p>Item [xxxxx] also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.</p> <p>Where the embedded foreign body is not completely removed, benefits are payable under the relevant attendance item (10916, 10900 or 10913).</p> <p>When charging item [xxxxx], the optometrist should document the nature of the embedded foreign body, subepithelial or intra-epithelial, and whether removal was undertaken using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device. The optometrist should also document whether rust rings were removed from the cornea using a dental burr, foreign body gauge or similar instrument with magnification by a slit lamp biomicroscope.</p> <p>Item [xxxxx] is to be billed in association with MBS item 10916 or item 10900 or 10913 depending on the length of consultation required to remove the foreign body.</p>

Any person presenting to and receiving treatment from an optometrist for a superficial embedded corneal foreign body would be eligible to receive subsidy covered under the proposed MBS item.

In the case of a person with CFB presenting to a GP who is unable to remove the object themselves, the patient may need to be referred to the closest available optometric service or emergency department (Christopher Hodgeg 2008). People living in rural areas are more likely to be treated by an optometrist than an ophthalmologist, given the scarcity of ophthalmologists in rural areas.

Any person presenting with a CFB would be eligible to access optometric services for removal of the body. If the complexity of the operation was beyond the skill of the optometrist, or if other complications were present (e.g. globe perforation, penetration >25%, or if the patient is unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication) it would be expected that the patient would be referred to an ophthalmologist.

7. Summary of Public Consultation Feedback/Consumer Issues

One professional body was not supportive of the final protocol and opposed this procedure being conducted in optometry, expressing specific concern with training and accreditation of optometrists in performing the service. Two professional bodies were supportive of the application, specifically in the interest of service provision in rural areas where access to specialists is limited.

Eight individuals identifying as optometrists provided their support for the application.

Consumer feedback also noted that the procedure was regarded as low frequency, but of high risk.

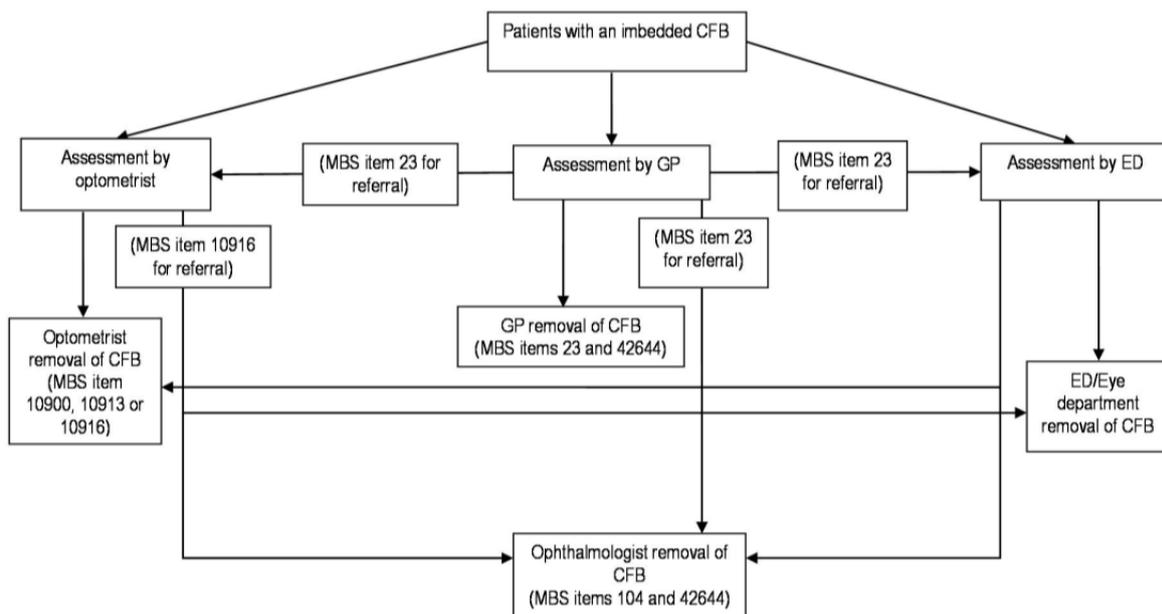
At ESC, it was clarified that removal of CFB is not high risk. However, consumer representatives noted that the proposed procedure would generally be viewed by consumers as low frequency/ high risk, despite not being ‘medically high risk’.

While there was no evidence presented comparing the slit lamp microscope to the loupe, consumers look for access to the best equipment.

8. Proposed intervention’s place in clinical management

Under the current treatment algorithm a patient would normally seek assistance from a convenient service provider such as an emergency department, GP clinic or optometrist, following which the CFB would be removed. If the removal is beyond the skill of the practitioner or other complications are present, the patient would be referred to an ophthalmologist. In the current scenario the optometrist will claim the service under a nonspecific attendance fee item (10900, 10913 or 10916). If removal is beyond the skill of the optometrist, they would claim a standard consultation item (10916) and refer patients to either an ophthalmologist or, in the absence of an ophthalmologist, an emergency department, or hospital eye department, if available.

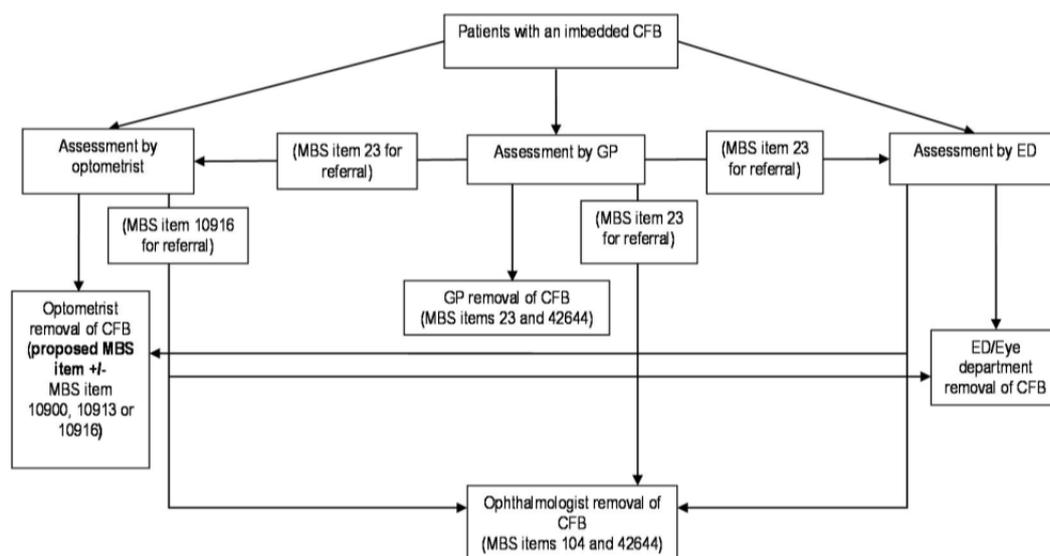
Current treatment algorithm



GP=general practitioners; ED=emergency department; CFB=corneal foreign body

In the proposed treatment algorithm, pathways will be identical to the current scenario with the exception that optometrists will claim a specific fee for the removal of corneal foreign bodies using the new item number, which may be used in conjunction with currently available consultation items.

Application proposed treatment algorithm



GP=general practitioners; ED=emergency department; CFB=corneal foreign body

It is proposed that by providing an additional MBS item under which an optometrist can claim for removal of a CFB, there is unlikely to be a change in practice, as optometrists currently perform the procedure. However, the applicant suggested that if there is increased public knowledge that optometrists may perform CFB removal, then there may be an increased proportion of these services performed by optometrists. The applicant claimed that it is more efficient to refer a patient to an optometrist than an ophthalmologist as they have shorter waiting times and are more prevalent.

It is assumed that currently, GPs may refer people to ophthalmologists more than optometrists, given that optometrists are unable to treat the more complex cases. However, data on referral patterns would need to be included in the evaluation. Expert advice suggested that a new MBS item is unlikely to directly change referral patterns for removal of superficial embedded CFBs.

9. Comparator

The proposed intervention is undertaken by more than one profession. The proposed profession have no specific MBS item. The comparators appear to be appropriate. The comparators are corneal foreign body with slit lamp performed by ophthalmologists and with a loupe or slit lamp by a GP. Services are also performed in emergency departments but these do not have a major role in this application.

Both comparison interventions are reimbursed under 42644, which is a historic MBS item.

10. Comparative safety

There is no available evidence.

11. Comparative effectiveness

There is no available evidence.

12. Economic evaluation

The lack of evidence precluded an economic evaluation.

13. Financial/budgetary impacts

The assessment report estimated that listing the procedure could cost \$1 to \$1.5 million a year if listed at the same fee as the comparator item.

14. Key issues from ESC for MSAC

ESC noted the current arrangement for removal of an embedded Corneal Foreign Body (CFB) is MBS item 42644 available for GPs and ophthalmologists. Alternatively the service is provided by hospital emergency departments. ESC noted there is no equivalent item for optometrists who perform the same service. Optometrists currently claim the assessment and treatment of a patient with an embedded CFB as a standard attendance item (10900, 10913 or 10916).

ESC noted a key issue is whether the introduction of the new MBS item would change the pattern of service provision from GP/Ophthalmologist to optometrist as assumed in the contracted assessment. If service patterns were to change then new patterns of utilisation would need to be accounted for and the question of relative effectiveness is very relevant.

ESC noted there was no evidence regarding safety presented in the application, and particularly noted the lack of evidence of any rates of adverse events. ESC agreed removal of an embedded CFB is relatively low risk as it is not a penetrating injury. In cases where there is a penetrating injury, the patient should be referred directly to an ophthalmologist.

ESC considered that the claim that removal of an embedded CFB by an optometrist is non-inferior to removal by an ophthalmologist or GPs was reasonable, despite the lack of clinical effectiveness evidence presented. ESC agreed that the clinical management pathway was unlikely to change if the proposed new item was listed.

ESC noted that no evidence was provided to support the assumption that there would be no change in service patterns from GP/ophthalmologists to optometrists performing this service (and noted calculations of resource use in the assessment assumed a gradual increase in presentations to optometrists and gradual decrease to GPs and ophthalmologists).

While the application provided no evidence of cost effectiveness, ESC noted that optometrists already provide the service and the request is about parity of reimbursement with GPs and ophthalmologists. ESC noted that, from 1 January 2015, optometrists will no longer be restricted to charge only the MBS fee for services.

ESC noted that the estimate of the number of embedded CFB removals currently performed by optometrists is highly uncertain, particularly as there are no reliable data available. However, ESC noted that if this item is listed, there is unlikely to be a change in practice, as there is very little risk of over servicing because it is an 'accidental' injury. ESC noted the applicant estimates the impact of introducing a separate item at between \$1.0-1.5 million a year for a service already being provided, for no additional health benefits.

ESC also noted the assessment did not take into account pharmaceutical use during or after the CFB removal, however there was no expected impact on the PBS. ESC noted the assessment did not consider private billing rates and on the whole, ignored patient costs, despite that from 1 January 2015 optometrists will no longer be restricted to charge only the MBS fee for services.

ESC noted that, in the sensitivity analyses, estimates of the total incremental cost of the proposed service ranged from \$900,000 to \$2.6 million per annum.

Training

ESC noted that optometrists are either therapeutically endorsed (currently approx. 1/3) or generally registered (currently approx. 2/3) and that from 2014 all graduates will be qualified to practice as therapeutically endorsed optometrists. Therapeutically endorsed optometrists are able to prescribe scheduled medicines and must demonstrate the ability to perform CFB removal.

Based on this fundamental difference in training, ESC considered it was appropriate that the descriptor should restrict the service to therapeutically endorsed optometrists only and agreed this could create an incentive to encourage generally registered optometrists to become therapeutically trained.

Equipment

ESC noted that a slit lamp would generally be used by ophthalmologists and optometrists while a loupe would be used in by a GP or emergency department. ESC noted that there was no evidence comparing the two tools, and considered that both were appropriate.

However, ESC also noted that the slit lamp could prove superior where there is a requirement to remove a rust ring, which is the result of a metallic CFB. If removal of the rust ring is not performed well, it may lead to a corneal ulcer.

The applicant has proposed the existing item descriptor (42644) be adopted for the optometry item with the removal of 'sclera' and PASC proposed the same schedule fee as for 42644.

ESC agreed that there should not be a requirement for co-claiming with a consultation item. ESC noted that PASC recommended that if a new item be listed it be claimed with a consultation item, on the basis that this was how GPs claimed the item. However, MBS data showed that only about 70% of these services are co-claimed with a consultation. Although ESC noted that this may be an overestimate if patients require consultation for another issue at the same time not relating to the corneal foreign body. ESC agreed that if an item were listed it could be claimable with a consultation item where it was clinically appropriate to take a patient history and other information related to the service, rather than being always claimed with a consultation.

Overall, ESC considered that this was not an evidence based assessment, with no evidence presented regarding whether optometrists should or should not provide the service or under what circumstances they should provide it. ESC questioned whether this application should proceed to MSAC and suggested that MSAC may wish to refer the application back to the Department on this basis.

15. Other significant factors

Nil.

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

Patients enjoy good access to optometric care and optometrists have been removing imbedded corneal foreign bodies (CFB) for over 30 years, commonly using a technique which best practice guidelines suggest supports better patient outcomes than alternative approaches commonly used in more generalist health settings where specialised eye care equipment may not be available. To support this to continue to occur in a sustainable manner, Optometry Australia believes that it is important that the cost of optometrists providing this care is reimbursed in a sustainable manner by the MBS as it currently is for General Practitioners and ophthalmologists. To this end we welcome MSAC's recommendation to support an item for optometrists to remove corneal foreign bodies equivalent to that for ophthalmologists and GPs; the proposed item would support patients to access quality, timely care for an acute presentation. We note that CFB removal is considered within the scope of practice for optometrists regardless of their therapeutic endorsement. Optometrists have been removing imbedded CFB for decades; systematic teaching of CFB removal to optometry students has been undertaken in Australia for 30 years and has been supported by continuing professional development. This predates accredited therapeutic training and endorsement of registration to prescribe scheduled medicines. We are not aware of any evidence which suggests that CFB removal undertaken by registered optometrists who are not therapeutically endorsed offer a lower standard of care or poorer patient health outcomes, and note that the most common broad spectrum antibiotic that is prescribed as a prophylaxis post CFB removal is an S3 (Pharmacist Only) over the counter medication. Optometry Australia believes there is no justification relating to patient safety or the clinician's knowledge and skill for restricting access to a Medicare rebate for CFB removal only to patients of therapeutically endorsed optometrists. We have concerns about the appropriateness of some of the assumptions used in estimating utilisation and financial implications, which we believe over inflate the likely cost to the MBS in introducing this new item, and don't fully capture potential patient benefits. We believe the likely cost to the MBS of supporting this new item will be much lower.

17. Further information on MSAC

MSAC Terms of Reference and other information are available on the MSAC Website at: www.msac.gov.au.