Australian Government

Medical Services Advisory Committee

Public Summary Document

1308 (CA) - Local anaesthetic (LA) nerve blockade for post-surgical analgesia

Applicant: **Australian Society of Anaesthetists**

Date of MSAC consideration: **MSAC 69th MSAC meeting 6-7 April 2017**

Context for decision: MSAC makes its advice in accordance with its Terms of Reference, visit the MSAC website

1. Purpose of application

An application requesting three new Medicare Benefits Schedule (MBS) listings for local anaesthetic peripheral nerve block (LANB) for post-surgical analgesia was received from the Australian Society of Anaesthetists by the Department of Health.

2. MSAC's advice to the Minister

After considering the available evidence presented in relation to safety, clinical effectiveness and cost-effectiveness, MSAC was unable to support the listing of LANB for post-surgical analgesia. MSAC accepted there was a clinical need for LANB in some patients but considered the clinical benefit, cost-effectiveness and financial impact for the proposed listing were highly uncertain based on the data presented.

MSAC considered it would be more informative if the scope of the application was changed to only consider particular LANBs with demonstrable and clinically significant health outcome benefits to patients and the healthcare system; such as chronic pain or phantom limb pain, compared to no nerve blockade. Together with clearer justification of the proposed fee, and elaboration of the out-of-pocket consequences for patients, a major revision of the economic analysis, costs and financial impact would also be required.

Any resubmission would need to be considered by ESC.

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

MSAC noted that the application sought to expand anaesthetists' access to MBS funding for local anaesthesia nerve blockade (LANB) for post-surgical analgesia. MSAC noted that the application proposed replacement of three current MBS items (22040, 22045 and 22050) relevant to specific nerves and specific surgeries, with three new MBS items covering all peripheral nerves which may need blockade for all types of surgeries. The three new MBS items would cover 'minor', 'major' and 'continuous' nerve blocks.

MSAC noted that the evidence presented was limited to a representative nerve block in each of the proposed MBS categories - paravertebral block (PVB; major), transversus abdominis plane block (TAP; minor) and continuous PVB (cPVB). MSAC recognised that this decision was made because of the large number of different types of nerve blocks and that supplemental information about another three nerve blocks was provided in an attempt to corroborate the main findings in each category. However, MSAC remained concerned that listing all peripheral nerve blocks on the basis of evidence presented for PVB, TAP block and cPVB may result in nerve blocks that have limited benefits being subsidised on the MBS.

With respect to the evidence presented for the representative blocks, MSAC had no major concerns about their safety. MSAC noted that for PVB, there was a reduction in nausea and vomiting compared with comparators (placebo saline, no block or epidural). For TAP block, there were similar rates of nausea and vomiting compared with comparators (placebo saline, no block, wound infiltration or epidural). When compared with an epidural, cPVB reduced nausea, vomiting, hypotension and urinary retention. Compared with other comparators (placebo saline, no block or wound infiltration), cPVB had similar or less nausea and vomiting.

With respect to the evidence presented for the effectiveness of the representative blocks, MSAC noted that:

- PVB reduced 24 hour post-operative morphine consumption by 7.0 mg (95% confidence interval [CI] 2.6–11.3; $p < 0.01$) compared with placebo saline or no block;
- TAP block reduced 24 hour post-operative morphine consumption by 14.6 mg (95% CI 9.5–19.7; $p < 0.01$) compared with comparators (placebo saline, no block, wound infiltration or epidural); and
- use of cPVB or an epidural resulted in similar levels of post-operative morphine consumption.

MSAC noted that a meta-analysis of cPVB compared with epidural found no difference in levels of post-operative pain at 4–8 hours, 24 hours or 48 hours (Ding X et al 2014). MSAC noted that meta-analysis of pain outcomes had not been undertaken for PVB and TAP block due to inconsistent reporting between studies. However, pain levels were generally reported to be lower in studies comparing PVB to placebo or no block and were generally lower or similar in studies comparing TAP block to any comparator.

MSAC noted that information on other possible benefits of LANB, such as length of hospital stay, recovery time, post-surgical chronic pain and quality of life was either very limited or not presented. MSAC suggested that information on these outcomes, if available, may enable a cost-utility analysis to assist the committee's decision making.

MSAC noted that the economic model relied upon cost analyses for each type of nerve block and cost offsets were limited to reductions in morphine dose. MSAC was concerned by the lack of patient centred outcomes, particularly pain, in the economic modelling. MSAC acknowledged that there were many different ways to measure pain reported in the evidence base but noted that there are methods to standardise pain measures to allow comparison and pooling of different studies. MSAC noted that including information about the impact of nerve blocks upon pain in an economic model was key to its decision making.

MSAC was concerned that the estimates of the number of services and the financial impact of listing LANBs were underestimated and that modelling of the likely growth in services was not undertaken. MSAC noted that the number of LANBs eligible for MBS subsidy would

increase because the current MBS items do not capture all types of LANB that can be performed, however the magnitude of this increase was uncertain. MSAC noted that the number of claims under the current MBS items has been steadily increasing over the past decade with just under 50,000 services claimed in 2012–13. MSAC was concerned that using Australian Institute of Health and Welfare (AIHW) procedural data to calculate that ~8,700 LANBs would be eligible for MBS subsidy underestimated the number of procedures. MSAC noted a study in which nine Australian hospitals managed to collect data on almost 8,200 peripheral nerve blockades over a two year period (Barrington MJ et al 2009).

MSAC suggested that the fee for continuous nerve blocks used in the economic modelling and financial estimates was too high and did not reflect that MBS fees for anaesthesia are calculated using the Relative Value Guide (RVG). MSAC noted that the RVG includes components that reflect the degree of difficulty of the procedure, initiation of management of anaesthesia, the total time of anaesthesia, any added complexities and associated therapeutic and diagnostic services. MSAC noted that any future cost analysis would need to reflect the use of RGV to calculate MBS costs.

MSAC noted that the fees included a patient co-payment but that the applicant strongly disagreed that out of pocket costs associated with LANB procedures would be common.

MSAC noted that the applicant had accepted a reduction in the number of units for major blocks from 4 units to 3 units.

MSAC accepted that there was a clinical need for LANB. However, MSAC was concerned by uncertainty around the clinical efficacy and cost-effectiveness of the different types of nerve block and the considerable uncertainty regarding the estimates of use and financial impacts.

MSAC suggested that an alternative approach to seeking MBS funding was to identify particular nerve blocks that have, or are likely to have, clear benefits followed by collection of evidence on these identified ‘high value’ nerve blocks to determine their safety, effectiveness and cost-effectiveness. MSAC suggested that the applicant provide advice on which nerve blocks are most likely to be ‘high value’.

MSAC noted that the main comparator for LANBs in any resubmission should be no block. However, MSAC noted that there may also be evidence that compares some nerve blocks to active comparators (e.g. local infiltration or joint infiltration associated with joint replacement surgery).

4. Background

MSAC has not previously considered LANB for post-surgical analgesia.

LANB is a similar service to those covered by the existing three MBS items (22040, 22045 and 22050).

5. Prerequisites to implementation of any funding advice

All medications associated with LANB are currently approved by the Therapeutics Goods Administration (TGA) for the indication of post-operative pain.

6. Proposal for public funding

The proposed MBS item descriptors for the post-operative LANB are presented in Table 1.

A separate item and fee has been proposed for each of the 'major', 'minor' and continuous categories. The Applicant has advised that the distinction between 'major' and 'minor' nerve blocks is artificial and related to the Applicant's experience of the complexity of service provision, rather than an accepted international classification.

In terms of the proposal, the following have been classified as major nerves: paravertebral, lumbar plexus, extrapleural, intercostal, coeliac plexus, cervical plexus, retrobulbar, peribulbar, sub-tenons and adductor canal. Major nerves are considered to be more complex in terms of service provision due to the location of the nerves and adjacent anatomical structures. Minor nerves are more straight-forward in terms of service delivery and thus have been allocated fewer proposed basic units. For all nerves, the provision of a catheter for continuous infusion is more complex and has been allocated a higher number of basic units.

Table 1 Proposed MBS item descriptor

Category [3] – [Therapeutic Procedures
MBS [item number] Major nerve block, proximal to the elbow or knee, including intercostal or abdominal wall nerve blocks, or plexus block (specify type), to provide postoperative pain relief. (Not to be used in conjunction with items X or Y*, or any item in the range 18213 to 18288) (4 units) [Relevant explanatory notes]
Fee: [$79.20]
MBS [item number] Minor nerve block (specify type) to provide postoperative pain relief (this does not include subcutaneous infiltration) (not to be used in conjunction with items X or Y, or any item in the range 18213 to 18288) (2 units) [Relevant explanatory notes]
Fee: [$39.60]
MBS [item number] Major peripheral nerve block, performed perioperatively, with the introduction of a catheter to allow continuous nerve blockade, to provide postoperative pain relief (not to be used in conjunction with items X or Y, or any item in the range 18213 to 18288) (5 units) [Relevant explanatory notes]
Fee: [$99.20]

The applicant preMSAC response noted that the term "abdominal wall" should be removed from the proposed descriptor for major nerve blocks, as this is covered under the minor nerve block descriptor.

7. Summary of Public Consultation Feedback/Consumer Issues

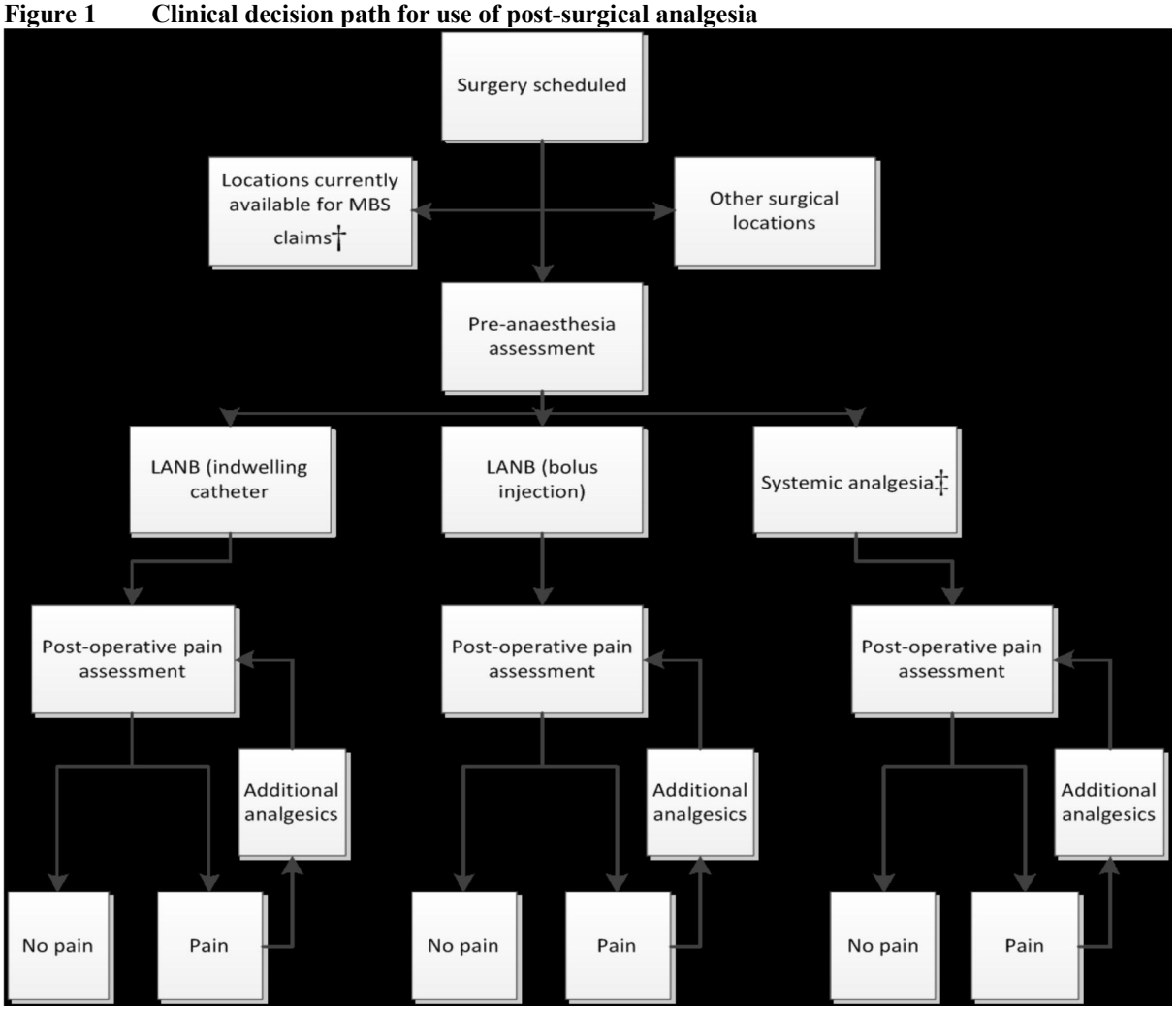
The Protocol Advisory Sub-Committee (PASC) received three responses from peak bodies. Overall feedback was positive however one peak body queried the exclusion of patients with chronic pain from the proposed population "whilst the use of local anaesthesia nerve blockades for such patients may be more complicated than other patients, to exclude them from consideration would be unreasonable".

8. Proposed intervention's place in clinical management

LANB is performed for a wide variety of surgical procedures. The technique utilises a variety of local anaesthetic drugs that act by producing a reversible barrier of peripheral nerve impulses at the source of the pain. The method of delivery depends on the specific nerve to be blocked, the surgery performed, and patient characteristics such as obesity or unusual anatomy. In general, LANB administration techniques are single dose, intermittent bolus, or continuous infusion via a catheter.

The flow chart provided in Figure 1 was developed in conjunction with, and agreed upon by, the PASC specifically for this assessment of LANB for post-operative analgesia.

Figure 1 Clinical decision path for use of post-surgical analgesia



† Peri-operatively performed in the induction room theatre or recovery room for the control of post-surgical pain via the femoral or sciatic nerves, in conjunction with hip, knee, ankle or foot surgery; or pain via the brachial plexus in conjunction with shoulder surgery.
‡ Systemic routes administration of drugs such as IV, oral, and epidural or intrathecal nerve blockade.

9. Comparator

For this assessment, the comparator to LANB was considered to be any other form of analgesia delivered via a systemic, oral, intravenous or subcutaneous infiltration route. Intrathecal or epidural nerve blocks for post-surgical analgesia were also comparators for certain patients.

Neuraxial analgesia - including epidural and intrathecal nerve block, involves the injection of local anaesthesia (LA) into the subarachnoid or epidural space. This may be a single injection, or as a repeated bolus or continuous infusion following catheter placement. Neuraxial analgesia is currently listed on the MBS (items 22031/22036)

Wound infiltration - refers to the infiltration of LA into the surgical wound to reduce post-operative pain. This service is not listed on the MBS.

Systemic analgesia - may be administered via oral, intravenous, intramuscular, subcutaneous or rectal route. For patients having procedures for which LANB would be considered a

comparator to systematic analgesia, the analgesic agent is likely to be opiates administered orally, by intermittent injection, by continuous infusion or by patient controlled analgesia (PCA). No MBS items are currently associated with systemic administration of analgesics via subcutaneous, intravenous, intramuscular or rectal route.

10. Comparative safety

Major block
Overall, PVB is a safe procedure, with adverse events rarely reported. One incidence of systematic exposure to LA was reported and resolved upon administration of diazepam. There was one report of inadvertent vascular puncture following PVB, the consequence of which was not reported. Sixteen RCTs reported no incidence of complication associated with PVB. No incidence of pulmonary complication was reported in any patient.

Meta-analysis showed a reduction in nausea (odds ratio (OR) = 0.293 (95% confidence interval (CI) = 0.182, 0.473), $p < 0.001$) and vomiting (OR = 0.30 (95% CI = (0.14, 0.65), $p < 0.001$) associated with PVB compared to comparator techniques. Heterogeneity was low ($I2$=0%).

Other safety outcomes were not meta-analysed due to infrequent and heterogeneous reporting. No study reported a difference in incidence of post-operative nausea and vomiting (PONV, reported as a single outcome), itch or drowsiness.

A systematic review on PCB (psoas compartment block) reported safety results consistent with those for PVB. The review reported that adverse events associated with PCB were rare. The most common side effect was epidural diffusion of LA resulting in bilateral block, which was reported by half of the included studies with an incidence ranging from three to 27 per cent.

Minor block
Overall, TAP is a safe procedure, with no serious adverse events and no intra-operative complications reported for any patient.

Meta-analysis showed a non-inferior risk of nausea (OR = 1.13 (95% CI = (0.82, 1.57), p = 0.45, $I2$ = 30.16%) and vomiting (OR = 0.8165 (95% CI = (0.509, 1.308), p = 0.398, $I2$ = 7.17%) between the TAP and comparator groups.

Other safety outcomes, including PONV, itching and drowsiness, were unable to be meta-analysed due to infrequent or inconsistent reporting. For each outcome, however, patients receiving TAP had equivalent or better outcomes than those receiving comparator techniques.

The results from 10 identified systematic reviews on TAP block were consistent with those of the primary studies. The systematic reviews reported no difference in safety outcomes between TAP and comparator techniques. Adverse events were rare and no review reported any incidence of haematoma, infection or nerve injury.

A systematic review on scalp block reported that adverse events were rare and there were no reported incidences of serious adverse event in any patient. No difference in adverse events between TAP and comparator techniques was reported in any of the included RCTs.

Continuous block
Continuous PVB is a safe procedure, with no serious complication associated with the nerve block reported by any study.

Compared to epidural, continuous PVB was associated with a lower risk of urinary retention (OR = 0.21, 95% CI = (0.10-0.44), $p < 0.0001$, $I2 = 0\%$), a lower risk of nausea and vomiting (OR = 0.49, 95% CI = (0.28-0.87), $p = 0.01$, $I2 = 27\%$) and a lower risk of hypotension (OR = 0.11, 95% CI = (0.05-0.25), $p < 0.00001$, $I2 = 0\%$) (Ding et al, 2014).

Compared to placebo, no block and wound infiltration, continuous PVB was also reported to be safe by all 11 RCTs. Four of the studies found that the PVB group had fewer complications than the comparator; three reported no difference in complications between the groups, and four found no complications in either group. No study reported that a comparator technique had superior safety outcomes over PVB.

A systematic review on continuous intercostal block found that adverse events were rare and mostly transient. No difference in pulmonary complications between continuous intercostal block and epidural or no block was reported by any study.

Overall, major, minor and continuous nerve blocks were found to be safe. No incidences of major events (e.g. permanent nerve damage or embolism) were reported for patients in any group. On the basis of the safety outcomes reported in the evidence base, it is suggested that LANB is no less safe than systemic analgesia, neuraxial analgesia or wound infiltration.

11. Comparative effectiveness

Major block
PVB was of superior or equivalent effectiveness to comparator techniques (placebo, no block, wound infiltration and epidural).

Meta-analysis showed PVB was associated with reduced morphine consumption in the 24 hours following surgery (Mean difference (MD) = 7.00 mg, 95% CI = (2.65, 11.34), $p < 0.01$, $\tau = 6.28$) and an increase in time to first analgesic request (MD = 120 min, 95% CI = (56.16, 149.66), $p < 0.01$, $\tau = 52.09$). Subgroup analysis showed that PVB was more effective than placebo block or no block, and was more effective than the comparator analgesia for breast and abdominal surgeries. Morphine consumption following thoracic surgery was found to be equivalent to the comparator technique (placebo), although this result is informed by data from a single RCT. No comparative data for these outcomes were available for wound infiltration and epidural.

Pain outcomes were not meta-analysed due to inconsistency relating to the type of pain scale reported by studies. In most studies, patients receiving PVB were reported to have lower pain compared to placebo or no block, and equivalent pain compared to epidural (1 RCT). For wound infiltration there was equivalent early pain and less late pain for the PVB group (1 RCT).

A systematic review on PCB reported effectiveness results consistent with those found for PVB. PCB provided superior pain relief to opiates up to eight hours post-surgery, and equivalent to opiates beyond eight hours. PCB was equivalent to epidural in two RCTs and equivalent to femoral nerve block in three RCTs.

Minor block
Meta-analysis of all data showed TAP was associated with reduced morphine consumption in the 24 hours following surgery (MD = 14.63 mg, 95% CI = (9.53, 19.68), $p < 0.01$, $\tau = 14.61$). Subgroup analysis showed TAP was superior to saline and no block and had equivalent effectiveness to epidural and wound infiltration. TAP reduced morphine consumption in patients undergoing abdominal and gynaecological surgeries. There was no

difference between groups for patients undergoing inguinal surgeries (2 RCTs). Across all studies, TAP was found to result in an increased time to first analgesia request (MD = 84.70, 95% CI = (58.77, 110.64), $p < 0.01$, $\tau = 53.19$). Subgroup analysis showed TAP was superior to saline and no block for patients undergoing abdominal and gynaecological surgeries. TAP had equivalent effectiveness to epidural (1 RCT) and wound infiltration (4 RCTs) comparators and was equivalent to the comparator for patients undergoing inguinal surgery (3 RCTs). If an RCT could not be included in the meta-analysis of safety or effectiveness outcomes, for any reason, its results were consistent with the pooled results.

Continuous block

Continuous PVB was associated with equivalent effectiveness compared to comparator techniques (Ding et al. 2014). There was no significant difference between continuous PVB and epidural for post-operative pain at four to eight hours (MD = 0.36, 95% CI = (-0.18, 0.89) $p = 0.19$, $I^2 = 68\%$), 24 hours (MD = 0.06, 95% CI = (-0.31, 0.42), $p = 0.77$, $I^2 = 54\%$), and 48 hours (MD = 0.13, 95% CI = (-0.32, 0.06), $p = 0.19$, $I^2 = 0\%$), nor was there a significant difference in morphine consumption between the intervention and epidural groups (MD = 1.11, 95% CI = (-2.20, 4.41), $p = 0.51$, $I^2 = 0\%$). The three additional systematic reviews and nine RCTs that reported effectiveness outcomes for continuous PVB compared to epidural reported results consistent with the systematic review by Ding et al. (2014). Compared to placebo, no block and wound infiltration, continuous PVB was reported to be as effective or more effective for early pain, late pain and morphine consumption. No study reported that a comparator technique had superior effectiveness over PVB.

A systematic review on continuous intercostal block found that the intervention was as good as or better than epidural and no block for pain, morphine consumption and forced expiratory volume outcomes.

Overall, LANB was associated with superior effectiveness when compared to systemic analgesia only (patients receiving placebo or no block). LANB was equivalent in effectiveness compared to an active comparator (epidural or wound infiltration). Across different types of surgery, LANB was associated with lower morphine use for abdominal, breast and gynaecological surgeries. Subgroup analysis on thoracic and inguinal surgery showed no significant difference in morphine consumption between intervention and comparator groups.

12. Economic evaluation

Cost analyses were conducted for the different types of nerve blocks. The cost of performing a nerve block varies by surgery and by type of nerve block, thus the analysis assessed the average cost by type of administration:

- Single bolus injection - ‘single dose nerve block’ (major and minor)
- Multiple bolus injection - ‘multiple dose nerve block’
- Continuous with an indwelling catheter - ‘continuous nerve block’.

The total estimated cost of a single dose – major nerve block is $162.02, and $132.32 for a minor block. The total estimated cost of a multiple dose major nerve block (assuming a total of two doses) is estimated to be $209.79. The total estimated cost of a continuous nerve block is estimated to be $772.97

Table 2 present the costs of the different nerve blocks and its comparators, with the associated MBS costs, cost savings, or costs avoided by performing a nerve block.

Table 2 Nerve block costs

Nerve block items	Base cost	MBS Cost including co-payment	MBS Cost excluding co-payment	Base cost minus potential cost offsets[a]
Single dose - major	$162.02	$112.40	$59.40	$160.35
Single dose – major replace intrathecal/epidural				$37.32 saving
Single dose - minor	$132.32	$82.70	$29.70	$130.65
Multiple dose	$209.79	$112.40	$59.40	$208.12
Multiple dose replace intrathecal/epidural				$10.46
Continuous dose	$772.97	$399.53	$346.53	$771.30
Continuous dose replace intrathecal/epidural				$573.64

[a] All nerve block items include a cost offset of $1.67 for reduction in morphine costs, and single dose major, multiple dose and continuous dose include the cost offset of $197.66 for the MBS cost of intrathecal and epidural injection

13. Financial/budgetary impacts

The estimated financial impact of funding the proposed MBS items is $2,649,702 per annum. This consists of major nerve blocks $910,314 (5,619 x $162.02), minor nerve blocks $129,326 (977 x $132.32) and continuous nerve blocks $1,610,061 (2,083 x $772.97).

When the direct MBS costs (excluding co-payments) are considered, the total financial impact to the MBS/government is $1,084,580 ($333,747 for major + $29,029 for minor + $721,804 for continuous).

The applicant preMSAC response noted that this cost would be offset by factors such as faster recovery times and hospital discharge resulting from the use of LANB. There is also evidence that the use of LANB for post-surgical analgesia results in a decrease in the incidence of chronic post-surgical pain syndromes, and emerging evidence that LANB may decrease recurrence of cancers after surgery for cancer removal.

14. Key issues from ESC for MSAC

ESC noted that the application sought to replace three current MBS items covering specific nerves and specific surgeries, with three new MBS items covering all peripheral nerves which may need blockade for all types of surgeries. The three new MBS items would cover ‘minor’, ‘major’ and ‘continuous’ nerve blocks. ESC noted that this could greatly increase the number of nerve blocks that would be subsidised by the MBS.

ESC noted that classification of nerve blocks as ‘minor’ or ‘major’ was arbitrary and based upon applicant experience rather than an international or national classification system. ESC suggested that the specific nerve blocks which are classified as major or minor be explicitly listed in the item descriptor.

ESC agreed that considering the evidence for a representative nerve block in each of the proposed MBS categories was a valid approach. The selected nerve blocks - paravertebral block (PVB; major), transverse abdominis plane (TAP; minor) and continuous PVB (cPVB) - had a large evidence base and were relevant to clinical practice.

ESC had no major concerns about the safety of nerve blocks, although it noted that there was limited information on serious adverse events.

In terms of clinical effectiveness, ESC noted that there was extensive heterogeneity in the meta-analyses for each type of nerve block (represented by wide prediction intervals), although this was not unexpected given the wide variety of surgeries, anatomical locations, patients and comparators included in the evidence base for each type of block.

Bearing these limitations in mind, ESC noted that:

- PVB increased time to first use of analgesia and reduced post-operative morphine consumption, nausea and vomiting compared with placebo and no block;
- TAP increased time to first use of analgesia, reduced post-operative morphine consumption and was associated with similar rates of nausea and vomiting compared with primarily placebo and no block; and
- use of cPVB or an epidural resulted in similar levels of post-operative morphine consumption and pain but cPVB reduced rates of nausea, vomiting, hypotension and urinary retention.

ESC noted that evidence for the comparative safety and effectiveness of nerve blocks against placebo or no block was greater than that for comparators such as epidural or intrathecal blocks or wound infiltration. However, in the limited number of studies that did compare nerve block with infiltration or epidurals, measures of early post-operative pain and late post-operative pain tended to be similar in both arms.

ESC was concerned that the cost offsets in the economic evaluation were limited to reductions in morphine dose. ESC suggested that including information on other patient benefits in the economic evaluation would be helpful for decision making (e.g. length of hospital stay or use of other types of (non-morphine) analgesia). ESC discussed including information about readmission rates in the evaluation but considered decisions to re-admit a patient post-surgery were influenced by many factors other than use of nerve blocks. ESC noted that in the pre-ESC response the applicant suggested reduced theatre time as an additional benefit.

ESC expected that the number of nerve block procedures eligible for MBS subsidies would increase under the suggested changes. ESC noted that the magnitude of this increase was uncertain because the current MBS items do not capture all types of nerve blocks that can be performed. In addition, ESC noted that there was uncertainty around the financial costs due to uncertainty about cost offsets and because of variability in the complexity of nerve blocks and the associated resource use.

ESC queried why the fees for the proposed MBS items were based upon 2–5 basic units while the current MBS item were based upon 2–3 basic units.

ESC suggested that it may be more reasonable to ask for more RVG units for continuous blocks (5 units) (compared with existing items). More specifically, the proposed major blocks (4 units) while current items are based on 2-3 units.

ESC noted that decisions made by the Anaesthesia Clinical Committee as part of the MBS review may impact upon this application.

From a consumer perspective, ESC noted that anaesthesia costs were a common cause of unexpected out of pocket expenses for patients.

15. Other significant factors

Nil

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

MSAC Application 1308 has not been supported by ESC. The benefits of local anaesthetic nerve blockade to patient are clear, and have been acknowledged by MSAC. The economics may be less certain, which is the reason for the application's rejection. However, significant flaws and omissions in the economic analysis were identified by the ASA. Certain clearly

proven clinical benefits also have clear economic benefits. MSAC appears to agree with this to some extent. Not all of the ASA's concerns were addressed, however. For example, the evidence behind the "copayment" for existing LANB services was never presented, despite repeated requests from the ASA, for both this application and application 1183 (2D ultrasound guidance for certain invasive procedures performed by anaesthetists). Of greater concern however, is that MSAC appears to be using flaws in the contracted assessment analysis to justify rejection of the application. These and other concerns are discussed in a more detailed paper, available on the ASA website at www.asa.org.au, under News/Latest News.

17. Further information on MSAC

MSAC Terms of Reference and other information are available on the MSAC Website:
visit the MSAC website