‘Mis-Guided’ Change to the MBS

Dr Shnier discusses the Government’s decision to remove injection items from the MBS.

Dr Ron Shnier - President - ADIA

As most of you would be well aware, the removal of injection items (nos 50124 and 50125) from the Medicare Benefit Schedule (MBS) was included as part of the 2009 Budget. The Australian Diagnostic Imaging Association (ADIA) understands that the measure was not aimed at the guided procedures performed by radiologists, but rather at the ‘blind’ procedures performed by other specialist practitioners as part of a consultation. However, this initiative has had the unintended consequence of affecting the appropriate item combinations for radiologists.

It was also unfortunate that yet again there was no consultation with industry prior to the change being announced.

The wording in the Budget measure suggests that the benefit being paid for a consultation with a specialist or surgeon already includes a payment for the administration of an injection. This may well be true for a procedure performed by a surgeon in his rooms without the benefit of imaging guidance. However, it is certainly not the case for a radiologist performing an injection guided by ultrasound, CT or fluoroscopy.

The accuracy of a ‘blind’ procedure is far lower than imaging guided procedures, which approach 100 per cent accuracy. As a result, it is not uncommon for specialists to refer a patient to a radiologist for a second attempt at the procedure when it becomes apparent their first, ‘blind’ attempt was unsuccessful. ADIA members report that the number of requests for these examinations has increased by up to 25 per cent over the past few years. There are a number of factors driving this increase, not least of which is the fact that targeted injections are a highly successful procedure, saving Pharmaceutical Benefits Scheme (PBS) costs in the form of analgesics and anti-inflammatory agents. Image-guided injections are now widely accepted as the next step in the therapeutic chain, either after or as an alternative to standard drug therapy.

Furthermore, over the past few years treatment for Achilles tendonitis has changed from a high-cost hospital procedure with a long patient recovery time to a guided injection. Similarly, many patients now referred to radiologists are not surgical candidates, that is, the treatment is for chronic back pain, joint pain in rheumatoid and so on. For these patients, the number of whom will only increase as our population ages, an injection is one of the few options available to them and it is best to target this properly with a guided injection.

ADIA recently met with Department of Health and Ageing staff to discuss our concerns in detail. We made it very clear that even with the $22 rebate for injections, these procedures are significantly under-funded, that they are only provided by a small number of practices, and that once again, the Government has made a decision on rebates that will disproportionately penalise comprehensive practices that offer all DI services, including the complex and under-funded services.

Unfortunately, given the various vagaries of government, we were unable to negotiate a solution that could be implemented from 1 November. Instead, the Department’s advice to us was that we should prepare a submission to the Medical Services Advisory Committee (MSAC), to have new, radiologist-appropriate, items listed on the Schedule. It is their view that it is up to the industry to fix anomalies within the Schedule by utilising the MSAC process.

Given the complexity, time and cost associated with the current MSAC process, this appears to be an inefficient way to maintain a MBS that is supposedly focused on meeting the needs of patients. Given the DI sector’s performance to date in this area, it is likely to be patients who will ultimately suffer both due to the delays in items being listed and the potential that providers will choose instead to offer the service outside the MBS and charge the patient the full cost.

Notwithstanding these concerns, ADIA has recently agreed to pursue this approach with MSAC and I would invite any of my colleagues interested in participating in the working group we have established for this purpose, to contact the ADIA Secretariat, catherine@adia.asn.au.

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australian diagnostic imaging association