RURAL DOCTORS ASSOCIATION OF AUSTRALIA

RDAA Response to Online Survey

Australian Government Department of Health and Aged Care consultation
Medicare Benefits Schedule (MBS) Review Advisory Committee: Post-implementation review of changes to electrocardiogram (ECG) MBS items

1. How did patient access to ECGs change, if at all, during the COVID-19 pandemic?

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2. Are there further changes that could be made to the current ECG MBS items that would both enable access to ECGs and ensure appropriate use?

RDAA supports recommendations that enable better access for rural and remote GPs and Rural Generalists (RGs) to the trace, report and clinical note MBS ECG items. There must be recognition that rural and remote doctors often provide whole service care: they perform the test, interpret results, record clinical notes on traces and provide formal reports; they work with cardiologists and other members of multi-disciplinary teams to provide integrated care.

RDAA proposes that, rather than setting a cap on the daily number of claimable services, the number should be determined by what is clinically required (and supported by notes).

- In rural and remote health settings, emergency care is often provided by rural and remote GPs and RGs. This means that there will be a higher number of ECGs performed by these doctors than by metropolitan GPs.

- If a patient presents with chest pain or an arrhythmia, current Acute Coronary Syndrome guidelines recommend that serial ECGs should be taken at 10-15 minute intervals and compared in sequence (and, where possible with previous ECGs) until the patient is pain free. https://www.heartfoundation.org.au/getmedia/6132a46d-5cfc-4cec-a9da-2ff380179bb1/Clinical_Guidelines_for_the_Management_of_Acute_Coronary_Syndromes_2016.pdf Each ECG requires individual interpretation. If a rural or remote doctor is unable to bill for more than two ECGs per day this means that they are effectively unpaid for their time if they follow the clinical guidelines.

- The context of practice must also be taken into account. In Victoria, rural doctors working in Urgent Care Centres bill the MBS for services as they are not funded by the Victorian health service. In South Australia, local health boards have also removed the payment following the implementation of the initial MBS policy changes. In these states, there is considerable

concern that this negatively impacts on patient care and that rural and remote doctors are being unfairly recompensed.

- Members from other states are also concerned that patient care may be negatively impacted if rural and remote doctors are not appropriately compensated for their skills, time and costs of service provision, and the number of clinically indicated ECGs is reduced. Rural GPs and RGs being able to utilise ECGs when clinically indicated is essential. Many other investigative tests or procedures are not available, and timely access to cardiologists, other consultant specialists and pathology services is limited. In rural and remote areas ECGs remain one of the cheapest and best starting investigations: they save lives.

3. The intent of the 1 August 2020 policy changes to the ECG MBS items was to reduce low value service provision. In balance, did this policy change achieve its intent? Why or why not?

RDAA believes that the measure used (how many ECGs are ordered) to inform the policy changes to the ECG MBS items was not fitting. It is, therefore, difficult to assess whether these policy changes have had the desired outcome.

The measure should be how many ECGs performed are clinically indicated (and supported by notes) and comply with current guidelines.

There also needs to be a recognition that the use and reporting of ECG MBS items will be higher in rural and remote locations, particularly in South Australia, Victoria and Tasmania where Medicare billing occurs in outpatient emergency-type services, and also in Government funded urgent care clinics.

If the issue is overuse of the ECG item numbers, then an 80/20-type rule (which flags doctors who provide 80 services more than 20 days in a month) could be developed to identify potential overuse by GPs and RGs and compliance measures implemented if needed.

4. What tangible changes, if any, have the 1 August 2020 ECG MBS amendments had in general practices and/or in rural and remote locations?

The 2020 ECG MBS amendments have negatively impacted on rural GPs and RGs whose skills, time and costs are no longer recognised.

Many rural and remote GPs and RGs undertake training in ECG interpretation for high-risk patients (those with heart disease; emergency presentations to primary care) and have invested in buying ECG equipment and training practice nurses, in order to provide best possible care for their patients. The implementation of the 2020 ECG MBS amendments means that these doctors are no longer adequately recognised or recompensed for the time it takes to perform tests, interpret and communicate results. In addition, the changes undermine the development and maintenance of skills needed by Rural GPs and RGs to be able to provide quality clinical care in rural and remote settings.

They report that the changes felt like ‘a kick in the guts’. This has contributed to increased stress and considerable frustration with what is seen as unfair changes because of overbilling by others. There continues to be concern that the measures used to underpin the case for the changes are based on

numbers without sufficient reference to clinical relevance, nor to the scope and circumstances of rural medical practice.

RDAA acknowledges that the intent of the original policy to reduce low value service provision but there is considerable concern that the focus on this provision has had the unintended consequence of reducing clinically indicated service provision.

5. Specialists and consultant physicians are able to claim MBS item 11705, for formal report only, when requested by a requesting practitioner. Item 11705 carries the same Schedule fee as MBS item 11707 for ECG, trace only, by a medical practitioner. Should the Schedule fee for MBS item 11705 differ from that of item 11707? Please provide details to explain why or why not?

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6. Please include any additional feedback on the Electrocardiogram Post-implementation Review Draft Report and recommendation to amend ECG MBS items. Or any further feedback that you would like to include on the review.

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