Medicare Benefits Schedule Review Taskforce

Report from the Colorectal Surgery Clinical Committee

2018
Important note

The views and recommendations in this review report from the clinical committee have been released for the purpose of seeking the views of stakeholders.

This report does not constitute the final position on these items, which is subject to:

- Stakeholder feedback;
- Consideration by the Committee;

Then

- Consideration by the MBS Review Taskforce;

Then if endorsed

- Consideration by the Minister for Health; and
- Government.

Stakeholders should provide comment on the recommendations via the MBSReviews@health.gov.au

Confidentiality of comments:

If you want your feedback to remain confidential please mark it as such. It is important to be aware that confidential feedback may still be subject to access under freedom of information law.
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1. **Executive summary**

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access.
- Best practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

The Colorectal Surgery Clinical Committee (the Committee) was established in 2018 to make recommendations to the Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The recommendations from the clinical committees are released for stakeholder consultation. The clinical committees consider feedback from stakeholders then provide recommendations to the Taskforce in a Review Report. The Taskforce considers the Review Reports from clinical committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

1.1. **Key recommendations**

The Committee reviewed 85 colorectal surgery items. The key recommendations from the Committee include:

- Amending the item descriptors of 31 items to accurately reflect current clinical practice and improve the definitions within these descriptors.
- Deleting 16 items that are clinically obsolete or describe procedures that are adequately encompassed in other colorectal surgery items.
- Combining similar procedures that are currently separated where there is no clinical reason to have separate items.
• Creating 13 new items for procedures that are currently being performed in practice, but are not as yet listed on the MBS. These are procedures which have evidence supporting their use and are increasingly considered best clinical practice. The new items include:

  o Ten new items for transanal total mesorectal excision (taTME); a standard surgical treatment for rectal cancer performed simultaneously by two surgeons/surgical teams.

  o One new item for ventral rectopexy; the preferred treatment for external rectal prolapse or symptomatic high grade internal prolapse.

  o Two new items for peritonectomy including hyperthermic intraperitoneal chemotherapy (HIPEC); surgical treatment to remove peritoneal mitotic disease.

• Three issues which the Committee would like to highlight as requiring further consideration across the MBS:

  o Access to stomal therapy nurses.

  o The use of enhanced recover after surgery (ERAS) principles.

  o Consumer health literacy.

1.2. Consumer impact

All recommendations have been summarised for consumers in Appendix A – Summary for Consumers. The summary describes the medical service, the recommendation of the clinical experts and rationale behind the recommendations and the changes for consumers. A full consumer impact statement is available in Section 5.

The Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations – and how, and why. Following public consultation, the Committee will assess the advice from consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendations to Government.

Both patients and providers are expected to benefit from these recommendations because they address concerns regarding patient safety and quality of care, and because they take steps to simplify the MBS and make it easier to use and understand.
The recommendations included in this report seek to simplify and streamline the portion of the MBS related to colorectal surgery items. These recommendations are aimed at ensuring MBS items for colorectal surgical services accurately reflect current best practice and modern techniques for the surgical management of conditions affecting the colon and rectum. Recommendations described in the sections below have been developed to improve access to MBS-funded colorectal surgical services for those Australians who are likely to benefit most from them.
2. About the Medicare Benefits Schedule (MBS) Review

2.1. Medicare and the MBS

2.1.1. What is Medicare?

Medicare is Australia’s universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

2.2. What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3. What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The Review is clinician-led, and there are no targets for savings attached to the Review.

2.3.1. What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.
• **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.

• **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient’s needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.

• **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

### 2.4. The Taskforce’s approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce’s brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug’s appropriate use criteria (1). The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value\(^1\), are misused\(^2\) and/or pose a risk to patient safety. This step includes prioritising items as “priority 1”, “priority 2”, or “priority 3”, using a prioritisation methodology (described in more detail below).

3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.

4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or Colleges. For complex cases, full appropriate use criteria were developed for the item’s explanatory notes.

5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.

6. Finalise the recommendations in preparation for broader stakeholder consultation.

7. Incorporate feedback gathered during stakeholder consultation and finalise the Review Report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).

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\(^1\) The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

\(^2\) The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

2.5. The Complete Medical Service concept

The Taskforce has recommended that each MBS item in the surgical section (T8) of the MBS represents a complete medical service and highlighted that it is not appropriate to claim additional items in relation to a procedure that are intrinsic to the performance of that procedure.

It is proposed that for surgical procedures, this principle will be implemented through restricting claiming to a maximum of three MBS surgical items for a single procedure or episode of care. For bilateral procedures benefits will be paid for a maximum of six surgical items for an episode of care. The existing multiple operation rule will be applied to these items.

The Taskforce’s rationale for making this recommendation is that 94 per cent of MBS benefits paid are for episodes where three or fewer items are claimed. On the occasions when more than three items are claimed in a single procedure or episode of care, there is often less transparency and greater inter-provider variability in benefits claimed for the same services, greater out-of-pocket expenditure for patients, and increased MBS expenditure that does not necessarily result in improved patient care.
Where the same group of three or more items are consistently co-claimed across providers, these represent a complete medical service and should be consolidated. Consolidation will improve consistency and optimise the quality of patient care; reduce unnecessary out-of-pocket costs for patients; and better correlate MBS expenditures with the actual services provided to patients.
3. **About the Colorectal Surgery Clinical Committee**

The Committee was established in 2018 to make recommendations to the Taskforce on the review of MBS items within its remit, based on rapid evidence review and clinical expertise.

### 3.1. Colorectal Surgery Clinical Committee members

The Committee consists of 14 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

**Table 1: Colorectal Surgery Clinical Committee members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/organisation</th>
<th>Declared conflict of interest</th>
</tr>
</thead>
</table>
| Associate Professor Andrew Stevenson (Chair) | Head of Colorectal Surgery, Royal Brisbane Hospital; Colorectal Surgeon, Holy Spirit Northside Hospital, Associate Professor of Colorectal Surgery, University of Queensland | User of MBS services  
Provider of MBS services  
Has received honoraria or worked as a proctor or consultant to a number of medical device companies that produce equipment used in laparoscopic or robotic surgeries (*Applied Medical, Intuitive Surgical, Johnson & Johnson, Medtronic, Olympus*) |
| Professor Michael Besser | MBS Review Taskforce ex-officio                                                             | User of MBS services                                                                                                                                               |
| Associate Professor Chris Byrne | Colorectal Surgeon, Royal Prince Alfred Hospital, The Mater Hospital, North Sydney and Sydney Day Surgery; Clinical Associate Professor, University of Sydney School of Medicine, Honorary Treasurer, Colorectal Surgical Society Australia and New Zealand Executive Council | User of MBS services  
Provider of MBS services  
Councillor, Colorectal Surgical Society of Australia and New Zealand |
| Dr Nuwan Dharmaratne        | General Practitioner                                                                     | User of MBS services  
Provider of MBS services                                                                                                                                          |
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
</table>
| Professor Alexander Heriot | Colorectal Surgeon, Epworth Freemasons Clarendon Street Hospital, Epworth Richmond Hospital; Clinical Director, Cancer Surgery Peter MacCullum Cancer Centre; Clinical Professorial Fellow, University of Melbourne; Chair of the Operations Committee of the Binational Colorectal Cancer Audit. | User of MBS services  
Provider of MBS services  
Physician Proctor, Johnson & Johnson, Medtronic. |
| Ms Rebecca James         | MBS Review Taskforce Consumer ex-officio                               | User of MBS services                                                  |
| Ms Alison Marcus         | Consumer                                                              | User of MBS services  
Former Registered Nurse and Stomal Therapy Nurse                          |
| Dr Elizabeth Murphy      | Colorectal Surgeon, Head of Colorectal Unit, Lyell McEwin Hospital; Calvary North Adelaide Hospital, Calvary Central Districts Hospital and Ashford Hospital Councillor, Colorectal Surgical Society Australia and New Zealand Executive Council | User of MBS services  
Provider of MBS services  
Councillor, Colorectal Surgery Society of Australia and New Zealand  
Physician Proctor, Medtronic |
| Ms Sarah O'Shannassy     | Colorectal Nurse and Advanced GI Surgical Program Manager, Royal Prince Alfred Hospital | User of MBS services  
Provider of MBS services  
Member, Australian Association of Stomal Therapy Nurses. |
| Professor Paul Pavli     | Gastroenterologist, Staff Specialist Gastroenterology Unit, Canberra Hospital | User of MBS services  
Provider of MBS services  
Board member, Gastroenterological Society of Australia |
| Ms Geraldine Robertson   | Consumer                                                              | User of MBS services                                                  |
| Associate Professor Margaret Schnitzler | Colorectal Surgeon, Royal North Shore Hospital, North Shore Private Hospital, Mater Misericordiae Hospital; Associate Professor, University of Sydney, Sub-Dean for Surgery and Academic Coordinator for Surgery, Northern Clinical School, University of Sydney | User of MBS services  
Provider of MBS services |

3.2. Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1 above.

It is noted that the majority of the Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Committee members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3.3. Areas of responsibility of the Committee

Colorectal surgery refers specifically to surgery of the colon and rectum (large intestine). This has historically been considered a component of general surgery. Increasingly colorectal surgery has become a field of subspecialty surgical management due to an increasing knowledge base - particularly for complex lower intestinal problems – increased training for minimally-invasive approaches (typically a further two years or more) and greater emphasis on careful anatomical dissection along embryological planes to achieve better patient outcomes.

The Committee reviewed 85 colorectal surgical MBS items. In the financial year 2016/17 these items accounted for approximately 82,000 services and $19 million in benefits. During the past five years, service volumes for these items have grown by 1.6% and total cost of
benefits paid has increased by 2.3%. This is largely in line with population growth which has increased by 1.6% for this period.

The MBS items reviewed by the Committee are shown in Table 2, below:

**Table 2: MBS item numbers reviewed by the Committee, by classification.**

<table>
<thead>
<tr>
<th>Classification</th>
<th>No.</th>
<th>Item Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemicolectomy, total colectomy and rectal resection items</td>
<td>14</td>
<td>32000, 32003, 32004, 32005, 32006, 32009, 32012, 32015, 32024, 32025, 32026, 32028, 32030, 32033</td>
</tr>
<tr>
<td>Synchronous surgeries</td>
<td>9</td>
<td>32018, 32021, 32042, 32045, 32046, 32054, 32057, 32063, 32066</td>
</tr>
<tr>
<td>Abdominoperineal resections</td>
<td>1</td>
<td>32039</td>
</tr>
<tr>
<td>Proctocolectomy and ileal pouch</td>
<td>3</td>
<td>32051, 32060, 32069</td>
</tr>
<tr>
<td>Rectal tumours</td>
<td>8</td>
<td>32096, 32099, 32102, 32103, 32104, 32105, 32106, 32108</td>
</tr>
<tr>
<td>Rectal prolapse</td>
<td>10</td>
<td>32111, 32112, 32114, 32115, 32117, 32120, 32123, 32126, 32129, 32131</td>
</tr>
<tr>
<td>Haemorrhoids, fistulae and abscesses</td>
<td>19</td>
<td>32132, 32135, 32138, 32139, 32142, 32145, 32147, 32150, 32153, 32156, 32159, 32162, 32165, 32166, 32168, 32174, 32175, 32177, 32180</td>
</tr>
<tr>
<td>Graciloplasty</td>
<td>4</td>
<td>32200, 32203, 32206, 32209</td>
</tr>
<tr>
<td>Sacral nerve leads</td>
<td>7</td>
<td>32210, 32213, 32214, 32215, 32216, 32217, 32218</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>1</td>
<td>11833</td>
</tr>
<tr>
<td>Other colorectal items</td>
<td>9</td>
<td>32029, 32036, 32047, 32171, 32183, 32186, 32212, 32220, 32221</td>
</tr>
</tbody>
</table>

**3.4. Summary of the Committee’s review approach**

The Committee completed a review of its items across four full committee meetings. These included two face-to-face meetings, two meetings via videoconference and three specialist subgroup videoconferences, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional provider and patient-level data, when required. The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report.
An inclusive set of stakeholders will be engaged in consultation on the recommendations resulting from this process, which are outlined in this report. Following this period of consultation, the Committee will consider stakeholder feedback before finalising the recommendations and presenting them to the Taskforce. The Taskforce will consider the report and stakeholder feedback before making recommendations to the Minister for Health for consideration by the Government.
4. **Recommendations**

The Committee reviewed 85 assigned colorectal surgery items and made recommendations based on evidence and clinical expertise, in consultation with relevant stakeholders. The item-level recommendations are described below. A consumer summary in table form can be found in Appendix A.

The Committee’s recommendations are that:

- 16 items should be deleted from the MBS;
- 31 items should be amended and/or have fees adjusted;
- 15 items should be combined into 7 items; and
- 23 items should remain unchanged.

The Committee also recommended the creation of 13 new items for services not currently reflected by the MBS.

The changes focus on encouraging best practice, modernising the MBS to reflect contemporary best practice, and ensuring that MBS services provide value for the patient and the healthcare system. Some of this can be achieved by:

- deleting items that are obsolete;
- consolidating or splitting items to reflect contemporary practice;
- modernising item descriptors to reflect best practice; and
- providing clinical guidance for appropriate use through explanatory notes.
4.1. Hemicolecotomy, total colectomy and rectal resection items

A hemicolecotomy involves the surgical removal of a section of the colon; either the right or left portion. Some patients may also require the formation of a stoma. A hemicolecotomy may be performed as a surgical treatment for bowel cancer, polyps, diverticulitis or inflammatory bowel disease (IBD).

A total colectomy involves removing the entire abdominal colon. A proctocolectomy involves removing both the abdominal colon and rectum, with or without the removal of the anal canal and sphincter complex.

Rectal resection involves that part of the large intestine which is located within the pelvis, surrounded by other important organs, large blood vessels and the nerves required for sexual, bladder and bowel function. Safe and complete removal of tumours involving the rectum is therefore considered more difficult than other parts of the large bowel, with a much higher chance of tumour recurrence compared with operations on large bowel located within the abdomen. Similarly, any restorative procedures after rectal resection are more likely to have complications such as anastomotic leak or damage to adjacent structures. A temporary defunctioning stoma is often required to allow the anastomoses to heal.

Minimally-invasive surgical (MIS) approaches to removal of the colon and rectum have become standard and preferred technique, when clinically appropriate. This has typically involved the use of laparoscopy with better patient-related outcomes when compared with traditional open surgery. Many studies have demonstrated that laparoscopy is more cost-effective and produces better patient outcomes than open colorectal surgery. Minimally invasive colorectal surgery is now the considered standard that should be offered to patients providing value to both patient and provider (2). However, the degree of training and the length of operation to safely complete these operations by a MIS approach are significantly greater, especially for patients with increased body mass index. Appropriately, clinicians would typically co-claim the laparoscopy item number 30390 in addition to the relevant item for colectomy.

The Committee reviewed 14 hemicolecotomy, total colectomy and rectal resection items.

Following the review of these items, the Committee recommended that:

- Five hemicolecotomy, total colectomy and rectal resection items remain unchanged.
- One hemicolecotomy item is deleted.
- The descriptors of eight items are amended.
Tables 3 to 6, below, show the standard Medicare service and benefits data considered during this review of hemicolectomy, total colectomy and rectal resection items. All data is by date of processing for the 2016/17 FY.

### 4.1.1. Recommendation 1

#### Table 3: Standard Medicare data for hemicolectomy, total colectomy and rectal resection items 32000 to 32015, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32000</td>
<td>Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)</td>
<td>$1,031.35</td>
<td>779</td>
<td>$532,209.60</td>
<td>11.40%</td>
</tr>
<tr>
<td>32003</td>
<td>Large intestine, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)</td>
<td>$1,078.80</td>
<td>4,157</td>
<td>$3,245,554.90</td>
<td>1.18%</td>
</tr>
<tr>
<td>32009</td>
<td>Total colectomy and ileostomy (Anaes.) (Assist.)</td>
<td>$1,364.60</td>
<td>121</td>
<td>$120,068.21</td>
<td>-2.87%</td>
</tr>
<tr>
<td>32012</td>
<td>Total colectomy and ileorectal anastomosis (Anaes.) (Assist.)</td>
<td>$1,507.40</td>
<td>147</td>
<td>$163,225.35</td>
<td>-3.32%</td>
</tr>
<tr>
<td>32015</td>
<td>Total colectomy with excision of rectum and ileostomy 1 surgeon (Anaes.) (Assist.)</td>
<td>$1,852.50</td>
<td>74</td>
<td>$101,277.55</td>
<td>-0.53%</td>
</tr>
</tbody>
</table>

**Recommendation:** Leave five hemicolectomy, total colectomy and rectal resection items unchanged.

**Rationale**

- These items adequately describe the procedures.
- These procedures reflect current best practice.
- These procedures are not provided under other items.
- These items are unlikely to be misused.
4.1.2. Recommendation 2

Table 4: Standard Medicare data for hemicolectomy item 32006, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32006</td>
<td>Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)</td>
<td>$1,150.35</td>
<td>853</td>
<td>$508,628.95</td>
<td>1.42%</td>
</tr>
</tbody>
</table>

Recommendation: Delete hemicolectomy item 32006.

Rationale

Item 32006 refers to the surgical procedure to remove the left side of the large bowel, known as a left hemicolectomy. If this is procedure is performed in conjunction with the creation of a stoma (an opening of the bowel onto the abdomen to allow the passage of stool), then item 32030 can be claimed. If a left hemicolectomy is performed in conjunction with the formation of an anastomosis, then item 32003 can be claimed. As a left hemicolectomy is always performed with either creation of a stoma or formation of an anastomosis, there is no other clinical reason to claim item 32006, rather than either 32030 or 32003.

The Committee noted data indicating some practitioners have been combined claiming (co-claiming) item 32006 with either item 32024 (high restorative anterior resection of the rectum with intraperitoneal anastomosis greater than 10cm from the anal verge), item 32025 (low restorative anterior resection of the rectum with extraperitoneal anastomosis less than 10cm from the anal verge) or item 32026 (ultra low restorative resection of the rectum, with or without covering stoma, with anastomosis 6cm or less from the anal verge). This co-claiming practice was previously appropriate when the splenic flexure of the colon had been mobilised in order to provide better mobilisation and potentially less tension on the anastomosis. However, as this practice of splenic flexure mobilisation is now considered a standard part of left colon/rectal resections, the Committee agreed it is no longer appropriate to co-claim these items together. The deletion of item 32006 will eliminate inappropriate co-claiming practices.
4.1.3. Recommendation 3

Table 5: Standard Medicare data for subtotal colectomy items 32004 and 32005, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32004</td>
<td>Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.)</td>
<td>$1,150.35</td>
<td>69</td>
<td>$55,263.05</td>
<td>1.84%</td>
</tr>
<tr>
<td>32005</td>
<td>Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.)</td>
<td>$1,299.55</td>
<td>404</td>
<td>$386,628.20</td>
<td>-0.10%</td>
</tr>
</tbody>
</table>

Recommendation: Amend the item descriptors for subtotal colectomy items 32004 and 32005.

The Committee recommended amending the item descriptors for items 32004 and 32005 to remove the reference to item 32006. Furthermore, the Committee recommended items 32004 and 32005 be amended to include a restriction on co-claiming these items at the same time as item 32030.

- It is recommended the amended descriptor for item 32004 read:
  - “Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32030 applies (Anaes.) (Assist)”

- It is recommended the amended descriptor for item 32005 read:
  - “Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32030 applies (Anaes.) (Assist)”

Rationale:

The Committee agreed the reference to item 32006 should be removed from the item descriptors for items 32004 and 32005 as item 32006 has been recommended for deletion.
within this report. Therefore, a co-claiming restriction with items 32004 and 32005 is no longer necessary.

The Committee recommended that items 32004 and 32005 should now include a restriction on co-claiming of either item at the same time as item 32030. This is because, with the deletion of item 32006, the procedure to perform a left hemicolectomy with formation of a stoma should not be claimed at the same time as the procedures described by items 32004 and 32005.

4.1.4. Recommendation 4

Table 6: Standard Medicare data for rectal resection items 32024 to 32033, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32024</td>
<td>Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)</td>
<td>$1,364.60</td>
<td>1,754</td>
<td>$1,767,063.25</td>
<td>-0.20%</td>
</tr>
<tr>
<td>32025</td>
<td>Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)</td>
<td>$1,825.30</td>
<td>1,233</td>
<td>$1,668,291.35</td>
<td>2.82%</td>
</tr>
<tr>
<td>32026</td>
<td>Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.)</td>
<td>$1,965.65</td>
<td>819</td>
<td>$1,188,534.55</td>
<td>-2.11%</td>
</tr>
<tr>
<td>32028</td>
<td>Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.)</td>
<td>$2,106.20</td>
<td>92</td>
<td>$143,277.50</td>
<td>11.24%</td>
</tr>
</tbody>
</table>
Recommendation: Amend the item descriptors for items 32024, 32025, 32026, 32028, 32030 and 32033.

The Committee recommended the descriptors for items 32024 and 32025 be amended to include restrictions on co-claiming with items 32000 or 32030.

The Committee recommended the item descriptor for item 32026 be amended to include a restriction on co-claiming this item at the same time as items 32000, 32030, 32103, 32104, 32106 and 32117.

Additionally, the Committee recommended that:

- The Explanatory Notes for items 32025, 32026 and 32028 be amended to include the following:
  
  “These procedures should be performed with the following requirements:

  o In an appropriate setting with ICU availability;

  o Include multidisciplinary team discussion of patient;

  o Have patient managed using Enhanced Recovery after Surgery (ERAS) principles;

  o In a setting with adequate access to stomal therapy nurse services.”

- The item descriptor for item 32024 be amended to read:

  o “Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32000, 32030, 32103, 32104 or 32106 applies (Anaes.) (Assist.)”

- The item descriptor for item 32025 be amended to read:

  o “Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or
without covering stoma not being a service associated with a service to which item 32000, 32030, 32103, 32104 or 32106 applies (Aaes.) (Assist.)”

- The item descriptor for item 32026 is recommended to be:
  
  o “Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge not being a service associated with a service to which item 32000, 32030, 32103, 32104, 32106 or 32117 applies (Aaes.) (Assist.)”

- The item descriptor for item 32028 be amended to read:
  
  o “Rectum, low or ultra-low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir not being a service associated with a service to which item 32000, 32030, 32103, 32104, 32106 or 32117 applies (Aaes.) (Assist.)”

- The Explanatory Note of item 32028 be amended to include additional wording as follows:
  
  o “This item is appropriately used by 1 surgeon incorporating transanal Total Mesorectal Excision."

- The Committee recommended the item descriptor for item 32030 be amended to read:
  
  o “Rectosigmoidectomy, including formation of stoma (Aaes.) (Assist.)”.

- The Committee recommended the item descriptor for item 32033 be amended to read:
  
  o “Restoration of bowel continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (Aaes.) (Assist.)”.

**Rationale**

The construction of a colonic reservoir can assist in improved postoperative rectum function by decreasing rates of stool urgency and incontinence. Currently, the creation of a colonic reservoir is listed on the MBS as item 32029. This is often performed and co-claimed with either 32026 or 32028. One of the aims of this review has been to develop complete medical services and so one of the recommendations of this report is the deletion of item 32029; therefore it becomes appropriate for rectum resection items 32026 and 32028 to incorporate construction of a colonic reservoir within their descriptors. The fee for items 32026 and 32028 should be increased to reflect the incorporation of constructing a colonic reservoir as part of these procedures.

It is inappropriate for item 32026 to be claimed at the same time as items 32000, 32006 or 32030 while this practice was historically appropriate when the splenic flexure of the colon
had been mobilised to provide better mobilisation of the anastomosis, with potentially less tension placed upon it. However, this practice of splenic flexure mobilisation is currently considered a standard part of rectal resections meaning that it is no longer appropriate to co-claim these items.

It is inappropriate for item 32025, 32026 or 32028 to be claimed at the same time as the procedure for abdominal rectopexy, item 32117. Co-claiming these items implies that there was insufficient length of rectum remaining to warrant the rectopexy. In the situation where a resection is required when performing a rectopexy, the anastomosis should ideally be above 10cm from the anal verge as this provides the patient with adequate function.

The Committee recommended that the word “Hartmann’s” be removed from the item descriptor for items 32030 and 32033 as it is considered unnecessarily specific and rarely performed in the same manner as the original description by Hartmann (i.e. not usually with mucous fistula). However, the Committee noted it is also appropriate to claim item 32030 for patients who have a large amount of rectum dissected, a procedure not accurately described as a Hartmann’s procedure.

4.2. Synchronous surgeries

The Committee reviewed nine items relating to synchronous surgeries; in which two surgical teams operate simultaneously.

Two-team surgeries are not restricted to bowel cancer surgeries. It can also be performed for other conditions such as ulcerative colitis and familial adenomatous polyposis (FAP).

Clinical evidence suggests the use of two surgical teams dramatically shortens operating time, resulting in:

- Better patient outcomes associated with shorter time under anaesthetics.
- Reduced hospital waiting times as more surgeries can be done in one day.
- Safer procedures associated with improved clinical outcomes (3).

Over the past 40 years there have been a number of advances in the surgical removal of the rectum and surrounding tissues (mesorectum), primarily for the treatment of rectal cancer. This is referred to as total mesorectal excision (TME) and is considered the standard surgical treatment for rectal cancer. This had previously been performed by “open” surgery via a long abdominal incision. More recently, TME surgery has included the use of minimally-invasive surgical (MIS) approaches such as laparoscopy and robotics, with similar patient oncology outcomes but without the need for a major abdominal incision. These procedures require a much greater skill set when performed using an MIS approach. There has also been
the progressive uptake by colorectal surgeons to perform the difficult pelvic dissection using a transanal approach from below. This has previously been described in the 1980’s but the modern approach involves use of MIS technologies to provide enhanced visualisation using a digital viewing platform (often in 3D) and insufflation of the lower rectum and pelvis or “pneumopelvis”. This approach has become known as transanal TME (taTME). There are many potential advantages to taTME, particularly in male patients with a narrow pelvis, low tumours close to the pelvic floor/sphincters, after pre-treatment with radiotherapy or in obese patients (4) (5).

TaTME requires an even higher skillset when performed via the perineal approach and is often performed by two surgical teams working synchronously.

The abdominal portion of the operation involves full mobilisation of the splenic flexure, high ligation of the large arteries and veins to the left colon and rectum. This is typically performed using an MIS approach by the abdominal team using CO₂ pneumoperitoneum. The perineal surgical approach is performed using a digital viewing platform and pneumorectum. The taTME team will perform the pelvic dissection and meet up with the dissection performed abdominal team above.

Transanal TME is technically more difficult than the abdominal component of the operation. As such, this is often performed by the surgeon to whom the patient had been initially referred, who has examined, investigated and assessed the patient for suitability for surgery and who is primarily responsible for the after-care of the patient. The post-operative period following surgery of the rectum typically involves 5-10 days inpatient stay, numerous investigations and occasional interventions or return to the operating theatre or radiological intervention. After-care may be provided by either the abdominal surgeon or the perineal surgeon, but typically not both.

When a two-team synchronous rectal surgery is performed, the Committee’s recommendation is to consider the role of the “primary surgeon” who is responsible for the post-operative care of the patient.

Whilst the MBS has provided for synchronous surgery in a number of clinical scenarios the current descriptors do not identify nor reflect the skills required of the perineal/taTME surgeon. There has also been a greater emphasis on the quality of surgical dissection along embryological planes which has increased the operative skillset required and the length of operation to provide better cancer-related outcomes for the patient. This rationale is relevant to paired items 32018 with 32021, 32042 with 32045, 32054 with 32057, and 32063 with 32066. Currently, these item number pairs assume aftercare to be provided by the abdominal surgeon. Going forward, it would be appropriate to create similar pairs whereby the aftercare component is loaded onto the perineal/taTME surgeon fee, with commensurate reduction in fee for the abdominal surgeon.
After considering the appropriateness of items relating to colectomy in contemporary surgical practice, the Committee recommended that:

- One synchronous surgery item be deleted;
- The descriptors for five synchronous surgery items be amended;
- The fee for three synchronous surgery items be reduced; and
- Ten new synchronous surgery items be created.

### 4.2.1. Recommendation 5

Table 7: Standard Medicare data for items for total colectomy by synchronous surgery, 32018 and 32021, 2016/17. Current combined fee of pair: $2,134.15.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32018</td>
<td>Total colectomy with excision of rectum and ileostomy, combined synchronous operation; abdominal resection (including aftercare) (Anaes.) (Assist.)</td>
<td>$1,570.85</td>
<td>11</td>
<td>$12,959.65</td>
<td>1.92%</td>
</tr>
<tr>
<td>32021</td>
<td>Total colectomy with excision of rectum and ileostomy, combined synchronous operation; perineal resection (Assist.)</td>
<td>$563.30</td>
<td>31</td>
<td>$12,611.05</td>
<td>44.04%</td>
</tr>
</tbody>
</table>

**Recommendation: Reduce the fee for item 32018.**

The Committee recommended the fee for this item be decreased to approximately $1,364.60.

**Rationale**

The proposed new fee reflects the reduced requirement for pelvic dissection required to be performed by the abdominal surgeon/surgical team, but still recognises the extensive mobilisation of the entire abdominal colon typically performed by minimally-invasive approach (similar to the current fee for item 32009 - total colectomy and ileostomy) which also includes the aftercare component.

**Recommendation: Amend the item descriptor for item 32021.**

- The Committee recommended the amended item descriptor for item 32021 read:
“Total colectomy with excision of rectum and ileostomy, including digital viewing platform and pneumorectum, combined synchronous operation; perineal resection (Assist.)”

- The Committee also recommended that the fee for item 32021 to be increased to approximately $1091.70.

Rationale

The Committee recommended changes to the current item descriptor for item 32021 to incorporate the use of a digital viewing platform and pneumorectum which provides the surgeon with enhanced visualisation for tumour excision and fee commensurate with increased skill and training required to perform taTME surgery with operating time similar to the abdominal component of the operation. The fee is derived from the current fee for item 32106, even though performing taTME is considerably more challenging to perform than transanal endoscopic or minimally invasive surgery. As the aftercare is provided by the abdominal surgeon, the fee for the perineal surgeon could be 20% of $1,364.60 (i.e. $1,091.70).

The new combined fee pair would be $2,456.30 in total, an overall difference of $322.15 over the prior combined fee of the pair. This represents the greater training, skill-set and time involvement of the perineal surgeon, commensurate with item 32106 (less the aftercare component). The pair of items was claimed 31 times in FY 2016/17 which would represent a difference of $9,986.65 per year.

It is expected these pairs of items would be used in approximately 50% of the 31 claims whereby the abdominal surgeon would be the primary provider of aftercare, which would represent a difference of $4,993.33 per year.

4.2.2. Recommendation 6

Table 8: Standard Medicare data for abdominoperineal resection by synchronous surgery items 32042 and 32045, 2016/17. Current combined fee of pair: $1,777.10.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32042</td>
<td>RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)</td>
<td>$1,293.15</td>
<td>38</td>
<td>$35,377.50</td>
<td>-5.71%</td>
</tr>
<tr>
<td>Item</td>
<td>Descriptor</td>
<td>Schedule fee</td>
<td>Services FY2016/17</td>
<td>Benefits FY2016/17</td>
<td>Services 5-year annual avg. growth</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>32045</td>
<td>RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.)</td>
<td>$483.95</td>
<td>30</td>
<td>$10,376.30</td>
<td>3.71%</td>
</tr>
</tbody>
</table>

**Recommendation: Amend the item descriptors for items 32042 and 32045.**

- The Committee recommended the item descriptor for item 32042 be amended to read:
  
  o “Rectum and anus, abdominoperineal resection of, combined synchronous operation abdominal resection including aftercare (Aaes.) (Assist.)”

- Additionally, the Committee recommended the fee for item 32042 be reduced to $1,031.35.

- The Committee recommended the item descriptor for item 32045 be amended to read:
  
  o “Rectum and anus, abdominoperineal resection of, combined synchronous operation - perineal resection/transanal total mesorectal excision including digital viewing system under pneumorectum (Assist.)”

- Additionally, the Committee recommended the fee for item 32045 to be increased to approximately $1,091.70.

**Rationale**

The surgical removal of rectum and anal canal (abdominoperineal resection - APR) may be achieved by a single surgeon (323 services in 2016/2017) or by two surgical teams, synchronous surgery (30 services in 2016/2017), which is more typically done when the pathology or patient morphology would predict a more difficult and prolonged operation. The recommended reduction in fee for item 32042 reflects the greater proportion of pelvic dissection being performed from the inferior end by the perineal surgeon (covered by item 32045), compared to the surgeon/surgical team operating via the abdominal approach. This would be similar to the dissection required for a rectosigmoidectomy (item 32030) with dissection into the pelvis and formation of end colostomy, and the proposed new fee is based upon the Schedule fee of item 32030. This includes the aftercare component by the abdominal surgeon. The more difficult part of the dissection (deepest within the pelvis) is performed by the perineal surgeon, often similar operating time and training.
The Committee recommended that the schedule fee for item 32045 be increased to better reflect the enhanced skillset required for the perineal surgeon, especially when using digital viewing platform and pneumorectum and fee commensurate with increased skill and training required to perform taTME surgery, with operating time similar to the abdominal component of the operation. The fee is derived from the current fee for item 32106, even though performing taTME is considerably more challenging to perform than transanal endoscopic or minimally invasive surgery. As the aftercare is provided by the abdominal surgeon, the fee for the perineal surgeon could be less 20% of $1,364.60 (i.e. $1,091.70).

### 4.2.3. Recommendation 7

**Table 9: Standard Medicare data for synchronous surgery item 32046, 2016/17.**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32046</td>
<td>RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.)</td>
<td>$747.90</td>
<td>13</td>
<td>$6,458.00</td>
<td>-9.15%</td>
</tr>
</tbody>
</table>

**Recommendation: Delete synchronous surgery item 32046.**

**Rationale**

Since the development of taTME, more extended excisions involving the pelvic floor and the practice of patient position change to prone (face-down) for the perineal dissection of the sphincters has become more widespread and considered to provide better patient outcomes (3). The use of two teams for combined synchronous excision (when not performed using a digital viewing platform and pneumorectum) is now rarely done and is not considered best practice. On the occasion of a second surgeon also providing assistance to the abdominal surgeon, item 32045 may still be used and that the recommended increased fee for item 32045 would still be suitable.
4.2.4. Recommendation 8

Table 10: Standard Medicare data for total colectomy by synchronous surgery items 32054 and 32057, 2016/17. Current combined fee of pair: $2,689.50.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32054</td>
<td>Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)</td>
<td>$2,126.20</td>
<td>2</td>
<td>$2,126.20</td>
<td>-24.21%</td>
</tr>
<tr>
<td>32057</td>
<td>Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)</td>
<td>$563.30</td>
<td>1</td>
<td>$563.30</td>
<td>-34.02%</td>
</tr>
</tbody>
</table>

Recommendation: Reduce the fee for item 32054.

The Committee recommended that the fee for item 32054 be decreased to approximately $1,575.20.

Rationale

The Committee recommended that the fee for item 32054 be decreased as a greater and more difficult proportion of the pelvic dissection is performed from below by the perineal surgeon using digital viewing platform and pneumorectum in conjoint surgery, rather than by the surgeon operating abdominally. This includes the aftercare component by the abdominal surgeon. The more difficult part of the dissection (within the pelvis) is performed by the perineal surgeon, often taking greater time and training. However, as the abdominal surgeon is also typically responsible for creation of the ileal reservoir (and including aftercare), this fee would be derived from abdominal colectomy item 32009 for which the fee is $1,364.60, plus 50% of creation of pouch based upon item 32029 for which the fee is $421.20, i.e. $1,364.60 plus $210.60 = $1,575.20.

Recommendation: Amend the item descriptor for item 32057.

- The Committee recommended the amended item descriptor for item 32057 read:
• “Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, perineal surgeon, including digital viewing platform and pneumorectum conjoint surgery (Assist.)”

• Additionally, the Committee recommended the fee for item 32057 be increased to approximately $1,091.70.

Rationale

The Committee recommended that the item descriptor for item 32045 be amended to incorporate the use of a digital viewing platform and pneumorectum. The Committee also recommended that the schedule fee be increased to reflect the greater skillset required for the perineal surgeon when using digital viewing platform and pneumorectum with operating time similar to the abdominal component of the operation. The fee is derived from the current fee of item 32106, even though performing taTME is considerably more challenging to perform than transanal endoscopic or minimally invasive surgery. As the aftercare is provided by the abdominal surgeon, the fee for the perineal surgeon could be less 20% of $1,364.60 i.e. $1,091.70.

The new combined fee of the pair would be $2,666.90, an overall difference of $22.60 less than the previous paired fee. This pair of items was claimed two times in FY2016/17 which would represent a difference of $45.20 less per year.

4.2.5. Recommendation 9

Table 11: Standard Medicare data for synchronous surgery items 32063 and 32066, 2016/17.
Current combined fee of pair: $2,689.50.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32063</td>
<td>Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)</td>
<td>$2,126.20</td>
<td>3</td>
<td>$2,126.20</td>
<td></td>
</tr>
<tr>
<td>32066</td>
<td>Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.)</td>
<td>$563.30</td>
<td>6</td>
<td>$563.30</td>
<td>24.57%</td>
</tr>
</tbody>
</table>
Recommendation: Reduce the fee of item 32063.

The Committee recommended that the fee for item 32054 be decreased to approximately $1,330.95.

Rationale

The Committee recommended that the schedule fee for item 32063 be reduced slightly as a greater proportion of the required pelvic dissection is performed inferiorly by the perineal surgeon using digital viewing platform and pneumorectum during conjoint surgery. Comparatively, the surgeon operating abdominally is required to perform a smaller proportion of the pelvic dissection. This includes the aftercare component by the abdominal surgeon. The more difficult part of the dissection (within the pelvis) is performed by the perineal surgeon, often taking greater time and training. However, as the abdominal surgeon is also typically responsible for creation of ileal reservoir (and including) aftercare, this fee would be derived from item 30379 laparotomy with division of adhesions for which the fee is $928.15, plus 50% of the fee for item 30562 colostomy, closure of, for which the fee is $595.00, plus 25% of creation of pouch based upon item 32029 for which the fee is $421.20, i.e. $928.15 plus $297.50 plus $105.30 = $1,330.95.

Recommendation: Amend the item descriptor for item 32066.

- The Committee recommended the item descriptor for item 32066 be amended to read:
  - “Rectal resection, formation of ileo-anal pouch with or without mucosectomy including mobilisation of ileostomy and with or without temporary loop ileostomy”.
- Additionally, the Committee recommended the fee for item 32066 be increased to approximately $1,091.70.

Rationale

The Committee recommended that the descriptor for item 32066 be amended to better reflect current practice and that the schedule fee be increased to address the increased skillset required for the perineal surgeon when using digital viewing platform and pneumorectum. The Committee also recommended that the Schedule fee be increased to better reflect the greater skillset required for the perineal surgeon when using digital viewing platform and pneumorectum with operating time similar to the abdominal component of the operation. The fee is derived from the current fee for item 32106, even though performing taTME is considerably more challenging to perform than transanal
endoscopic or minimally invasive surgery. As the aftercare is provided by the abdominal surgeon, the fee for the perineal surgeon could be less 20% of $1,364.60 i.e. $1,091.70.

The new combined fee of the pair would be $2,053.85 in total, an overall difference of $635.65 less than the previous paired fee. This pair of items was claimed six times in FY2016/17 which would represent a difference of $3,813.90 less per year.

4.2.5. Recommendation 10

Table 12: Proposed item descriptors for recommended new taTME items 320AA and 320BB (proposed combined total fee $2,624.80).

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>320AA</td>
<td>Rectum, low or ultra-low restorative resection, with stapled or peranal sutured coloanal anastomosis, combined synchronous operation incorporating transanal total mesorectal excision, abdominal resection including aftercare, with or without colonic reservoir, with or without covering stoma, other than a service associated with a service to which item 320BB, 320CC or 320DD by the same provider applies (Aaes.) (Assist.)</td>
</tr>
<tr>
<td>320BB</td>
<td>Rectum, low or ultra-low restorative resection, with stapled or peranal sutured coloanal anastomosis, combined synchronous operation, perineal dissection including digital viewing platform and pneumorectum, perineal surgeon, excluding aftercare, with or without covering stoma, other than a service associated with a service to which item 320AA, 320CC or 320DD by the same provider applies. (Aaes.) (Assist.)</td>
</tr>
</tbody>
</table>

Recommendation: Create two new items for rectal restorative resection incorporating taTME, including aftercare.

- The Committee recommended the Explanatory Notes for the proposed new items 320AA and 320BB include the following:
  - “That this procedure be performed with the following requirements:
    - Be performed in an appropriate setting with ICU availability;
    - Multidisciplinary team discussion of patient;
    - Have patient managed using Enhanced Recovery after Surgery (ERAS) principles.
  - This item should not be claimed by one surgeon performing both perineal and abdominal procedures. In this instance item 32028 is appropriately claimed.”

- Additionally, the Committee recommended the proposed schedule fee for item 320aa be $1,364.60.
Additionally, the Committee recommended the proposed schedule fee for item 320bb be $1,260.20.

Rationale

The Committee recommended the creation of two new items that accurately describe surgical treatment of rectal cancer using taTME surgery and which incorporate the provision of aftercare by the primary surgeon.

The proposed new item 320AA considers the role of the abdominal surgeon as the primary surgeon and includes a restriction on co-claiming of this item for the same patient on the same day with item 320BB, by either the abdominal or the perineal surgeon. The role of the abdominal surgeon is to mobilise the splenic flexure, with high ligation of the vessels and mobilisation to the upper rectum followed by anastomosis. This is similar to the extent of dissection for a high anterior resection (item 32024). In these combined synchronous surgeries where the majority of the difficult pelvic dissection is performed from below by the perineal/taTME surgeon, the proposed Schedule fee for the abdominal surgeon would be based on item 32024, including aftercare i.e. $1,364.60.

The perineal/taTME surgeon uses skills and techniques derived from other transrectal endoscopic operations utilising digital viewing platform and pneumorectum (item 32106). A colonic reservoir (item 32029) is often created by the perineal surgeon who also performs the anastomosis. The Committee has recommended this item to be incorporated into a complete medical service for the descriptors of items 32026 and 32028 i.e. $1,364.60 plus (50% of $421.20) less 20% aftercare component = $1,575.20 x 80% = $1,260.20.

The proposed new item 320BB considers the role of the perineal surgeon as the primary surgeon and includes a restriction on co-claiming of this item for the same patient on the same day with item 320AA, by either the abdominal or the perineal surgeon.

The Committee agreed it is necessary to create separate items where aftercare is assigned to either the abdominal surgeon or perineal surgeon as aftercare is not typically provided by both surgeons.

The new combined fee pair for synchronous surgery would be $2,624.80, an overall difference of $308.00, compared with a single surgeon operation (items 32028 and 32029) which represents the greater training, skill-set and time involvement with these more difficult cases, as well as the increased training required of the perineal surgeon, commensurate with item 32106 plus item 32029 (less aftercare). The single surgeon item was claimed 92 times in FY2016/17. It is expected these pairs of items would be used in approximately 50% of the 92 claims where the abdominal surgeon would be the primary provider of aftercare, which would represent a difference of $14,168.00 per year.
Table 13: Proposed item descriptors for recommended new taTME items 320CC and 320DD (proposed combined total fee of $2,606.55).

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>320CC</td>
<td>Rectum, low or ultra-low restorative resection, with stapled or peranal sutured coloanal anastomosis, combined synchronous operation incorporating transanal total mesorectal excision, abdominal resection excluding aftercare which is to be primarily provided by the perineal surgeon, with or without colonic reservoir with or without covering stoma, other than a service associated with a service to which item 320AA, 320BB or 320DD by the same provider applies. (Anaes.) (Assist.)</td>
</tr>
<tr>
<td>320DD</td>
<td>Rectum, low or ultra-low restorative resection, with stapled or peranal sutured coloanal anastomosis, combined synchronous operation, perineal dissection including digital viewing platform and pneumorectum, perineal surgeon, including aftercare, with or without covering stoma, other than a service associated with a service to which item 320AA, 320BB or 320CC by the same provider applies. (Anaes.) (Assist.)</td>
</tr>
</tbody>
</table>

Recommendation: Create two new items for rectal restorative resection incorporating taTME, excluding aftercare.

- The Committee recommended the Explanatory Notes for items 320CC and 320DD include the following:
  - “That this procedure be performed with the following requirements:
    - Be performed in an appropriate setting with ICU availability;
    - Multidisciplinary team discussion of patient;
    - Have patient managed using Enhanced Recovery after Surgery (ERAS) principles.
  - This item should not be claimed by one surgeon performing both perineal and abdominal procedures. In this instance item 32028 is appropriately claimed.”

- Additionally, the Committee recommended the proposed Schedule fee for item 320CC be $1,031.35 (i.e. $1,364.60 less aftercare).

- Additionally, the Committee recommended the proposed Schedule fee for item 320DD be $1,575.20 (including aftercare).

Rationale

The Committee recommended the creation of two new items that accurate describe surgical treatment of rectal cancer using taTME surgery and excluding provision of aftercare by the surgeon not considered to be the primary surgeon.
Recommended item 320CC is intended for use by the abdominal surgeon operating synchronously with the perineal surgeon where the abdominal surgeon is not responsible for aftercare.

The proposed Schedule fee is based on the same rationale as for proposed new items 320AA and 320BB but with the aftercare component interchanged between abdominal and perineal/taTME surgeons.

The new combined fee pair for synchronous surgery would be $2,624.80, an overall difference of $289.75, compared with a single surgeon operation (items 32028 and 32029) which represents the greater training, skill-set and time involvement with these more difficult cases, as well as the increased training required of the perineal surgeon, commensurate with items 32106 and 32029 (less aftercare). The single surgeon item was claimed 92 times in FY2016/17. It is expected these pairs of items would be used in approximately 50% of the 92 claims where the perineal/taTME surgeon would be the primary provider of aftercare, which would represent a difference of $13,328.50 per year.

Table 14: Proposed item descriptors for recommended new items for total colectomy with taTME by synchronous surgery recommended for creation, with aftercare interchanged to the perineal surgeon.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Proposed schedule fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>320EE</td>
<td>Total colectomy with excision of rectum and ileostomy, combined synchronous operation; abdominal resection whereby the perineal surgeon is the primary surgeon responsible for aftercare (Anaes.) (Assist.)</td>
<td>$1150.35</td>
</tr>
<tr>
<td>320FF</td>
<td>Total colectomy with excision of rectum and ileostomy, combined synchronous operation; perineal resection, perineal/transanal total mesorectal excision surgeon (including aftercare) (Assist.)</td>
<td>$1,467.50</td>
</tr>
</tbody>
</table>

Recommendation: Create two new items for total colectomy with taTME by synchronous surgery.

Rationale

TaTME involves resecting the same area as reflected by current colectomy items, using a different approach. It is not a new procedure; however, it does use new technology.

Traditionally, the abdominal component of the operation includes dissection almost to the pelvic floor. The perineal team performs a mucosectomy or removal of sphincter complex, joining up with the dissection from above and typically does not carry responsibility for aftercare. However, when synchronous two-team taTME surgery is performed, this involves an alternative approach with the creation of a pneumopelvis, more extensive dissection of the mesorectum within the pelvis, requiring much greater skill and training this part of the
operation is usually performed by the surgeon to whom the patient may have been initially referred. In that instance, that taTME / perineal surgeon is often the primary carer for the patient and has responsibility for the aftercare. The advantages of the two-team approach include greater safety, shorter overall operating time/theatre utilisation and potentially better outcomes for the patient and hospital. Consensus statements and comparative studies support this two-team approach.

The Committee recommended the creation of two new item numbers for total colectomy with taTME. The proposed fees for new items 320EE and 320FF are recommended in line with procedures of similar length and complexity and are essentially the same as paired surgical team items 32018 and 32021 with aftercare interchanged to the perineal surgeon.

The new combined fee pair would be $2,456.30 in total, an overall difference of $322.15 than the prior combined fee of the pair. This represents the greater training, skill-set and time involvement of the perineal surgeon, commensurate with item 32106 (less the aftercare component). The pair of items was claimed 31 times in FY2016/17 which would represent a difference of $9,986.65 per year.

It is expected these pairs of items would be used in approximately 50% of the 31 claims whereby the perineal/taTME surgeon would be the primary provider of aftercare, which would represent a difference of $4,993.33 per year.

Table 15: Proposed item descriptors for recommended new items for rectal resection and mucosectomy using taTME recommended for creation with aftercare interchanged to the perineal surgeon.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Proposed schedule fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>320GG</td>
<td>Rectal resection with or without mucosectomy with ileostomy closure and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (Anaes.) (Assist.)</td>
<td>$896.50</td>
</tr>
<tr>
<td>320HH</td>
<td>Rectal resection with or without mucosectomy with ileostomy closure and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy, including digital viewing platform and pneumorectum conjoint surgery, perineal surgeon (including aftercare) (Assist.)</td>
<td>$1,793.00</td>
</tr>
</tbody>
</table>

Recommendation: Create two new items for rectal resection and mucosectomy using taTME.

Rationale

The above rationale for proposed new items 320EE and 320FF is also pertinent to proposed new items 320GG and 320HH.
The Committee recommended the creation of two new item numbers for rectal resection and mucosectomy with taTME. The proposed schedule fees for new items 320GG and 320HH are recommended in line with procedures of similar length and complexity and are essentially the same as paired surgical team items 32063 and 32066 with aftercare interchanged to the perineal surgeon.

**Table 16: Proposed item descriptors for recommended new items for abdominoperineal resection by synchronous surgery using taTME, with aftercare interchanged to the perineal surgeon (combined proposed Schedule fee $2,189.30).**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Proposed schedule fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>320JJ</td>
<td>Rectum and anus, abdominoperineal resection of, combined synchronous operation, abdominal surgeon, whereby the perineal surgeon is the primary surgeon responsible for aftercare (Anaes.) (Assist.)</td>
<td>$825.10</td>
</tr>
<tr>
<td>320KK</td>
<td>Rectum and anus, abdominoperineal resection of, combined synchronous operation - perineal resection/transanal total mesorectal excision including digital viewing system under pneumorectum (Assist.)</td>
<td>$1,364.20</td>
</tr>
</tbody>
</table>

**Recommendation: Create two new items for rectal restorative resection incorporating taTME, excluding aftercare.**

- The Committee recommended the Explanatory Notes for proposed new items 320JJ and 320KK include the following:
  - “That this procedure be performed with the following requirements:
    - Be performed in an appropriate setting with ICU availability;
    - Multidisciplinary team discussion of patient;
    - Have patient managed using Enhanced Recovery after Surgery (ERAS) principles.
  - This item should not be claimed by one surgeon performing both perineal and abdominal procedures. In this instance item 32028 is appropriately claimed.”

- Additionally, the Committee recommended the proposed Schedule fee for item 320JJ be $825.10 (i.e. $1,031.35 less aftercare).
- Additionally, the Committee recommended the proposed Schedule fee for item 320KK be $1,364.20 (including aftercare).
Rationale

The rationale is similar to that described for the proposed changes to fees for the combined synchronous operations for abdominoperineal (non-restorative) resection of the anus and rectum, but with interchange of the aftercare component from abdominal to the perineal/taTME surgeon.

The new combined fee pair would be $2,189.30 in total, an overall difference of $412.20, which represents the greater training, skill-set and time involvement of the perineal surgeon, commensurate with item 32106 (including the aftercare component). The matching pair of items (items 32042 and 32045) was claimed 38 times in FY2016/17 in which the abdominal surgeon would be responsible for aftercare. It is expected these new pairs of items would be used in approximately 50% of the 38 claims whereby the perineal/taTME surgeon would be the primary provider of aftercare, which would represent a difference of $7,831.80 per year.

4.3. Abdominoperineal resections items – single surgeon

An abdominoperineal resection is a surgical procedure during which the sigmoid colon, rectum and anal sphincter are removed via both abdominal and perineal incisions during the surgical excision of a rectal cancer.

Surgical advances have led to the development of alternative procedures in which the anal sphincter may sometimes be spared, such as taTME. However an abdominoperineal resection is often still be necessary for rectal tumours located in the distal third of the rectum.

The Committee reviewed one abdominoperineal resection item.

4.3.1. Recommendation 11

Table 17: Standard Medicare data for abdominoperineal resection item 32039, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32039</td>
<td>RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.)</td>
<td>$1,535.05</td>
<td>323</td>
<td>$343,977.00</td>
<td>1.56%</td>
</tr>
</tbody>
</table>

Recommendation: Leave abdominoperineal resection item 32039 unchanged.

Rationale
After considering standard Medicare data and clinical evidence, the Committee agreed item 32039 should remain unchanged. This is because:

- The item adequately describes the procedure.
- The procedure is required for patients in which other surgical methods of rectal tumour excision are not possible.
- The procedure is not provided under other items.
- There is unlikely misuse of this item.

4.4. Proctocolectomy and ileal pouch items

A proctocolectomy involves removal of both the abdominal colon and the rectum, with or without removal of the anal canal and sphincter complex.

The Committee reviewed three proctocolectomy and ileal pouch items.

The Committee recommended that:

- Two proctocolectomy and ileal pouch items remain unchanged; and
- The descriptor for proctocolectomy and ileal pouch item is amended.

4.4.1. Recommendation 12

Table 18: Standard Medicare data for proctocolectomy and ileal pouch items 32051 and 32069, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32051</td>
<td>Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)</td>
<td>$2,316.60</td>
<td>52</td>
<td>$88,757</td>
<td>-3.77%</td>
</tr>
<tr>
<td>32069</td>
<td>Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)</td>
<td>$1,713.65</td>
<td>6</td>
<td>$7,711</td>
<td>-12.94%</td>
</tr>
</tbody>
</table>

Recommendation: Leave proctocolectomy and ileal pouch items 32051 and 32069 unchanged.
Rationale

After considering the standard Medicare data and relevant clinical evidence, the Committee agreed that items 32051 and 32069 should remain unchanged. This is because:

- The items adequately describe the procedures.
- The procedures reflect current best practice.
- The procedures are not provided under other items.
- There is unlikely misuse of these items.

4.4.2. Recommendation 13

Table 19: Standard Medicare data for proctocolectomy and ileal pouch item 32060, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32060</td>
<td>Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Aaes.) (Assist.)</td>
<td>$2,316.60</td>
<td>63</td>
<td>$107,516</td>
<td>2.75%</td>
</tr>
</tbody>
</table>

Recommendation: Change the descriptor for item 32060.

- The Committee recommended the item descriptor for item 32060 be amended to read:
  - “Restorative proctectomy involving rectal resection with formation of ileal reservoir and ileoanal anastomosis including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (Aaes.) (Assist.)”

Rationale

The Committee considered an appropriate item descriptor for this item and agreed the amended descriptor better describes the procedure and reduces confusion with a standard ileostomy closure.

Since the initial description of this operation, the techniques and instruments have improved whereby a mucosectomy is often not required and now seldom performed.
4.5. Rectal tumour items

The Committee reviewed eight items for excision of rectal tumours. These items refer to local excision of the rectal tumour without removal of the adjacent mesorectum, lymph nodes or colon.

The Committee recommended that:

- One rectal tumour item remain unchanged;
- One rectal tumour item be deleted;
- Four rectal tumour items be combined into two items;
- The descriptors of two rectal tumour items be amended.

4.5.1. Recommendation 14

Table 20: Standard Medicare data for excision of rectal tumour item 32108, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32108</td>
<td>Rectal tumour, transspincteric excision of (Kraske or similar operation) (Anaes.) (Assist.)</td>
<td>$999.65</td>
<td>14</td>
<td>$9,746.80</td>
<td>22.87%</td>
</tr>
</tbody>
</table>

Recommendation: Leave excision of rectal tumour item 32108 unchanged.

Rationale

After considering the standard Medicare data and relevant clinical evidence, the Committee agreed item 32108 should remain unchanged. This is because:

- The item adequately describes the procedure.
- The procedure reflects current best practice.
- The procedure is not provided under other items.
- There is unlikely misuse of this item.
4.5.2. Recommendation 15

Table 21: Standard Medicare data for excision of rectal tumour item 32105, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32105</td>
<td>Anorectal carcinoma per anal full thickness excision of (Anaes.) (Assist.)</td>
<td>$483.95</td>
<td>82</td>
<td>$28,261.60</td>
<td>-6.38%</td>
</tr>
</tbody>
</table>

Recommendation: Delete excision of rectal tumour item 32105

Rationale

The Committee agreed the service provided under item 32105 is sufficiently described within items 32103 and 32099.

Additionally, excision of small anal squamous carcinomas is appropriately claimed under item 31356.

Therefore, the Committee agreed there is no need for item 32105 to remain on the MBS and its deletion will not affect patients or the service they receive.

4.5.3. Recommendation 16

Table 22: Standard Medicare data for excision of rectal tumour items 32099 and 32102, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32099</td>
<td>Rectal tumour of 5cm or less in diameter, per anal submucosal excision of (Anaes.) (Assist.)</td>
<td>$333.20</td>
<td>345</td>
<td>$72,021.95</td>
<td>1.26%</td>
</tr>
<tr>
<td>32102</td>
<td>Rectal tumour of greater than 5cm in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.)</td>
<td>$634.70</td>
<td>80</td>
<td>$37,190.85</td>
<td>-6.67%</td>
</tr>
</tbody>
</table>

Recommendation: Combine rectal tumour items 32099 and 32102 into one item.

- The Committee recommended that items 32099 and 32102 be combined into one item.
- The Committee recommended the fee for the new combined item be set at a level approximately equivalent to that of the lower fee item ($333.20).
Additionally, the Committee recommended the item descriptor for the new combined item include the following:

- “Rectal tumour, per anal excision of (Anaes.) (Assist.)”

**Rationale:**

Numerous studies have demonstrated superior patient outcomes associated with the use of a digital viewing platform and pneumorectum for the removal of large rectal lesions, compared with transanal technique (4) (6) (7). However, it may be still appropriate to remove smaller lesions by a transanal technique. The Committee agreed removing the size description on the relevant item should provide a disincentive for surgeons to attempt the removal of larger lesions without the use of digital viewing platform and pneumorectum. The Committee agreed that doing so would be inappropriate and not in line with current clinical best practice.

### 4.5.4. Recommendation 17

**Table 23: Standard Medicare data for rectal biopsy item 32096, 2016/17.**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32096</td>
<td>Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)</td>
<td>$256.95</td>
<td>210</td>
<td>$35,579.20</td>
<td>10.76%</td>
</tr>
</tbody>
</table>

**Recommendation:** Amend the item descriptor for rectal biopsy item 32096.

- The Committee recommends the item descriptor for item 32096 be amended to read:

  - “Rectal biopsy, full thickness, to diagnose or exclude Hirschsprung’s Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)”

**Rationale**

The Committee agreed the addition of a specific reference in the item descriptor to Hirschsprung’s Disease, provides patients with the appropriate information regarding the purpose of the procedure and better describes why the procedure is done.
**Recommendation 18**

Table 24: Standard Medicare data for excision of rectal tumour items 32103, 32104 and 32106 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32103</td>
<td>Rectal tumour, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Aneas.) (Assist.)</td>
<td>$772.30</td>
<td>109</td>
<td>$61,875.05</td>
<td>0.18%</td>
</tr>
<tr>
<td>32104</td>
<td>Rectal tumour, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Aneas.) (Assist.)</td>
<td>$999.65</td>
<td>160</td>
<td>$117,261.10</td>
<td>12.96%</td>
</tr>
<tr>
<td>32106</td>
<td>Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Aneas.) (Assist.)</td>
<td>$1,364.60</td>
<td>36</td>
<td>$34,275.90</td>
<td>12.47%</td>
</tr>
</tbody>
</table>

Recommendation: Combine items 32103 and 32104 into one item and amend the descriptor of item 32106.

- The Committee recommended items 32103 and 32104 be combined into one item with the item descriptor for the new combined item to read:
  - “Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a
• The Committee recommended the item descriptor for item 32106 be amended to read:
  o “Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.)”

Rationale

There are a number of surgical platforms now available to achieve transanal excision of rectal tumours. All of these incorporate a digital viewing system and creation of space by insufflation with carbon dioxide (pneumorectum). This often involves suturing of the defect or full thickness excision of the lesion, neither of which is typically done when a polyp is removed using colonoscopy. The amended descriptors of the 32103 and 32104 combined item and the amended descriptor of item 32106 provides an updated description of the technology involved. Additionally the new descriptor provides a point of differentiation to the removal of rectal polyps during colonoscopy.

In the new item generating from combining items 32103 and 32104, the Committee recommended the size indicator be removed from the descriptor noting that while the size of the tumour may influence the time and difficulty associated with performing the operation successfully, there are a number of other factors which are more relevant. These include the height of the tumour from the anal verge, involvement of a rectal fold and previous surgery/endoscopic removal of the lesion. Removing the size description reduces the number of item numbers for this section but acknowledges the skillset required for this type of surgery.

4.6. Rectal prolapse items

Rectal prolapse is the protrusion of part of the bowel out through the anus. The level of prolapse is ranked by severity:

1. Internal (incomplete) prolapse – the rectum has prolapsed but does not protrude through the anus.

2. Mucosal – the interior lining of the rectum protrudes through the anus.

3. External (complete) – the full thickness of the rectum protrudes through the anus.
Rectal prolapse may occur in young children or in the elderly, with the exact cause unknown. Prolapse in children generally resolves without requiring surgery. In adults, mucosal prolapse is treated by rubber banding or by surgery. For external prolapse, surgery is usually required, with several different procedures that can be performed.

The Committee reviewed 10 items for the repair of rectal prolapse.

The Committee recommended that:

- Two rectal prolapse items remain unchanged.
- Two rectal prolapse items be deleted.
- Two rectal prolapse items be combined.
- Two rectal stricture items be combined.
- The descriptors for two rectal prolapse items be amended.
- One new rectal prolapse item is created.

### 4.6.1. Recommendation 19

**Table 25: Standard Medicare data for anoplasty and rectocele repair items 32123 and 32131, 2016/17.**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32123</td>
<td>Anal stricture, anoplasty for (Anaes.) (Assist.)</td>
<td>$333.20</td>
<td>166</td>
<td>$32,387.40</td>
<td>25.65%</td>
</tr>
<tr>
<td>32131</td>
<td>Rectocele, transanal repair of rectocele (Anaes.) (Assist.)</td>
<td>$533.60</td>
<td>214</td>
<td>$53,843.50</td>
<td>9.17%</td>
</tr>
</tbody>
</table>

**Recommendation: Leave items 32123 and 32131 unchanged.**

**Rationale**

After considering the standard Medicare data and clinical evidence, the Committee agreed items 32123 and 32131 should remain unchanged. This is because:

- The current items adequately describe the relevant procedures.
- The procedures reflect current best practice.
- The procedures are not provided under other items.
- There is unlikely to be misuse of these items.
4.6.2. Recommendation 20

Table 26: Standard Medicare data for repair of rectal prolapse items 32120 and 32126, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32120</td>
<td>Rectal prolapse, perineal repair of (Aaes.) (Assist.)</td>
<td>$256.95</td>
<td>783</td>
<td>$69,510.10</td>
<td>15.02%</td>
</tr>
<tr>
<td>32126</td>
<td>Anal incontinence, Parks’ intersphincteric procedure for (Aaes.) (Assist.)</td>
<td>$483.95</td>
<td>11</td>
<td>$3,448.50</td>
<td>-6.01%</td>
</tr>
</tbody>
</table>

Recommendation: Delete items 32120 and 32126.

Rationale

After considering the standard Medicare data for items 32120 and 32126, the Committee agreed these items should be deleted from the MBS. Key considerations leading to this decision included:

- Item 32120 is frequently co-claimed with item 32139. However, there is probably insufficient justification for this to continue as a separate item, particularly considering item 32111 (Delorme procedure) more fully describes the extent of dissection required to treat rectal prolapse via a perineal approach.

- Parks’ intersphincteric procedure for anal incontinence is a rarely performed procedure with no evidence to support its continued use, especially when many newer procedures and technologies have become available for the treatment of faecal incontinence.

- In the small number of instances where this procedure is performed, it would be appropriate to claim item 32129 (repair of anal sphincter), or to consider pelvic floor neuromodulation.
4.6.3. Recommendation 21


<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32111</td>
<td>Rectal prolapse, Delorme procedure for (Anaes.) (Assist.)</td>
<td>$634.70</td>
<td>950</td>
<td>$449,680.46</td>
<td>14.11%</td>
</tr>
<tr>
<td>32112</td>
<td>Rectal prolapse, perineal recto-sigmoidectomy for (Anaes.) (Assist.)</td>
<td>$772.30</td>
<td>37</td>
<td>$21,773.30</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Recommendation: Combine items 32111 and 32112 into one item

- The Committee recommended items 32111 and 32112 be combined with the item descriptor for the new item to read:
  - “Perineal repair of rectal prolapse. Not being a service described by 32139 and not to be co-claimed with 32139. (Anaes) (Assist)”

Rationale

There are currently a number of procedures available to treat rectal prolapse, which have similar degrees of complexity. As the number of services for item 32112 is expected to decrease further in the future, it would be appropriate to combine the two items.

The descriptor of the combined item is similar to the descriptor of item 32120 (now recommended for deletion); however it is important to specify that perineal repair of prolapse should not be performed at the same time as haemorrhoidectomy items 32138 and 32139.

The Committee recommends that the fee for the new combined item is set at the previous fee of item 32111 ($634.70), based upon greater service volume.

4.6.4. Recommendation 22

Table 28: Standard Medicare data for treatment of rectal stricture items 32114 and 32115, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32114</td>
<td>Rectal stricture, per anal release of (Anaes.)</td>
<td>$174.45</td>
<td>134</td>
<td>$11,748.60</td>
<td>0.92%</td>
</tr>
</tbody>
</table>
Recommendation: Combine items 32114 and 32115 into one item

- The Committee recommended items 32114 and 32115 be combined into one item with the amended descriptor for the new item to read:
  
  o “Rectal stricture, treatment of (Anaes)”.

- Additionally, the Committee recommended the fee for the combined item be approximately $126.85.

Rationale

There are currently a number of procedures available to treat rectal strictures. The services provided under items 32114 and 32115 each have a similar degree of complexity. Therefore, the Committee agreed it would be appropriate to combine the two. This would serve to simplify the MBS.

- The Committee agreed the fee for the combined item should be set at a value proportional to service volumes of items 32114 and 32115.

### 4.6.5. Recommendation 23

Table 29: Standard Medicare data for repair of rectal prolapse item 32117, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32117</td>
<td>Rectal prolapse, abdominal rectopexy of (Anaes.) (Assist.)</td>
<td>$999.65</td>
<td>671</td>
<td>$369,092.75</td>
<td>10.14%</td>
</tr>
</tbody>
</table>

Recommendation: Change the descriptor for item 32117.

The Committee recommended item 32117 be amended to include restrictions on co-claiming on the same day as items 32025 or 32026.

- The Committee recommended the amended item descriptor for item 32117 read:
"Rectal prolapse, abdominal rectopexy of, not being a service associated with a service to which items 32025, 32026 applies (Anaes) (Assist)"

Rationale

Treatment of rectal prolapse by an abdominal approach may include removal of the sigmoid colon for which item 32024 would be claimed. However, it would be inappropriate to remove a significant portion of the rectum during treatment of rectal prolapse by abdominal approach. Items 32025 and 32026 describe rectal resection procedures which would not be appropriately performed at the same time as item 32117 and it is recommended that a restriction on co-claiming these items should be put in place.

4.6.6. Recommendation 24

Table 30: Standard Medicare data for anal sphincter repair item 32129, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32129</td>
<td>Anal sphincter, direct repair of (Anaes.) (Assist.)</td>
<td>$634.70</td>
<td>175</td>
<td>$55,574.05</td>
<td>-2.24%</td>
</tr>
</tbody>
</table>

Recommendation: Amend the item descriptor for item 32129.

- The Committee recommended the item descriptor for item 32129 be amended to read:
  - “Anal sphincter repair (Anaes) (Assist)”.

Rationale

The Committee agreed the current item broadly reflects the relevant service for the direct repair of anal sphincter and that this procedure remains relevant in contemporary surgical practice. However, the Committee recommended a minor change to the wording of the item descriptor to remove superfluous words.
4.6.7. Recommendation 25

Table 31: Proposed item descriptor for recommended new item for repair of rectal prolapse.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>320LL</td>
<td>VENTRAL RECTOPEXY Treatment of external rectal prolapse or symptomatic high grade internal rectal prolapse by laparoscopy or robotic-assistance involving and including dissection of the recto-vaginal septum to the pelvic floor, fixation of prosthesis to the rectum, with or without vaginal vault and sacrum, and including any associated pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse. Items 35595 and 35597 not to be co-claimed by the same surgeon claiming 32118. A second surgeon may claim 35597 if the patient requires synchronous repair of symptomatic upper vaginal vault prolapse involving fixation of separate prosthesis secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse.</td>
<td>$1473.20</td>
</tr>
</tbody>
</table>

Recommendation: Create a new item for repair of rectal prolapse.

The Committee agreed a new item for the repair of rectal prolapse using ventral rectopexy is necessary.

- The Committee recommended the item descriptor for the new item reads:
  - “VENTRAL RECTOPEXY Treatment of external rectal prolapse or symptomatic high grade internal rectal prolapse by laparoscopy or robotic-assistance involving and including dissection of the recto-vaginal septum to the pelvic floor, fixation of prosthesis to the rectum, with or without vaginal vault and sacrum, and including any associated pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse. Items 35595 and 35597 not to be co-claimed by the same surgeon claiming 32118. A second surgeon may claim 35597 if the patient requires synchronous repair of symptomatic upper vaginal vault prolapse involving fixation of separate prosthesis secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse.”

- Additionally, the Committee recommended the fee for the new item be set at approximately $1473.20.

Rationale

Ventral rectopexy is a surgical procedure for treatment of external or significant internal rectal prolapse. It is currently considered the preferred treatment for surgical management of full thickness rectal prolapse (8).
Ventral rectopexy is performed via a minimally invasive approach and multiple sutures deep in the pelvis with difficult access, resulting in longer procedure duration than traditional suture or mesh rectopexy. It involves the use of a prosthesis and full mobilisation of the anterior plane of the rectum to the pelvic floor. It is a very similar procedure to the procedure 35597 laparoscopic sacro-colpopexy which is performed by gynaecologists for vaginal vault prolapse and a fee identical to that procedure is recommended.

### 4.7. Haemorrhoid, fistula and abscess items

The Committee reviewed 19 items for the treatment of haemorrhoids, fistula and abscesses.

The Committee recommended that:

- One haemorrhoid item, three fistula items and two abscess items to remain unchanged;
- Three haemorrhoid items and one fistula be deleted;
- Two anal skin tag/anal polyp excision items to be combined;
- Two anal wart items to be combined; and
- The descriptors for two haemorrhoidectomy items, two fissure items and one fistula item be amended.

#### 4.7.1. Recommendation 26

**Table 32: Standard Medicare data for haemorrhoidectomy, fistulae and abscess items 32147, 32159, 32162, 32166, 32174 and 32175, 2016/17.**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32147</td>
<td>Perianal thrombosis, incision of (Anaes.)</td>
<td>$45.10</td>
<td>2,818</td>
<td>$105,997.42</td>
<td>-4.85%</td>
</tr>
<tr>
<td>32159</td>
<td>Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)</td>
<td>$333.20</td>
<td>2,858</td>
<td>$638,644.45</td>
<td>2.27%</td>
</tr>
<tr>
<td>Item</td>
<td>Descriptor</td>
<td>Schedule fee</td>
<td>Services FY2016/17</td>
<td>Benefits FY2016/17</td>
<td>Services 5-year annual avg. growth</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>32162</td>
<td>Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Aaes.) (Assist.)</td>
<td>$483.95</td>
<td>1,719</td>
<td>$607,221.40</td>
<td>6.06%</td>
</tr>
<tr>
<td>32166</td>
<td>Anal fistula - readjustment of Seton (Aaes.)</td>
<td>$206.20</td>
<td>528</td>
<td>$79,392.65</td>
<td>-2.23%</td>
</tr>
<tr>
<td>32174</td>
<td>Intra-anal, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Aaes.)</td>
<td>$88.80</td>
<td>384</td>
<td>$27,017.20</td>
<td>-7.98%</td>
</tr>
<tr>
<td>32175</td>
<td>Intra-anal, perianal or ischio-rectal abscess, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Aaes.)</td>
<td>$162.65</td>
<td>1,996</td>
<td>$186,507.71</td>
<td>2.18%</td>
</tr>
</tbody>
</table>

Recommendation: Leave items 32147, 32159, 32162, 32166, 32174 and 32175 unchanged.

Rationale

The Committee considered the standard Medicare data and clinical evidence related to the current services for haemorrhoidectomy, repair of anal fistula and drainage of ischiorectal abscesses and recommended the current items remain unchanged. This is because:

- These items adequately describe the relevant procedures.
- The procedures are reflective of current best practice.
- The procedures are not provided under other items.
- There is unlikely to be misuse of these items.

4.7.2. Recommendation 27

Table 33: Standard Medicare data for items for repair of haemorrhoids and fistulae, 32132, 32138, 32153 and 32168, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32132</td>
<td>Haemorrhoids or rectal prolapse sclerotherapy for (Aaes.)</td>
<td>$45.10</td>
<td>3,646</td>
<td>$71,919.80</td>
<td>-6.81%</td>
</tr>
<tr>
<td>32138</td>
<td>Haemorrhoidectomy including excision of anal skin tags when performed (Aaes.)</td>
<td>$367.75</td>
<td>1,694</td>
<td>$452,798.40</td>
<td>-1.67%</td>
</tr>
<tr>
<td>Item</td>
<td>Descriptor</td>
<td>Schedule fee</td>
<td>Services FY2016/17</td>
<td>Benefits FY2016/17</td>
<td>Services 5-year annual avg. growth</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>32153</td>
<td>Anus, dilatation of, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Aaes.)</td>
<td>$70.10</td>
<td>104</td>
<td>$5,270.05</td>
<td>-3.30%</td>
</tr>
<tr>
<td>32168</td>
<td>Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (Aaes.)</td>
<td>$131.75</td>
<td>85</td>
<td>$7,908.90</td>
<td>-5.70%</td>
</tr>
</tbody>
</table>

**Recommendation: Delete haemorrhoidectomy items 32132, 32138 and 32153 and review of fistula item 32168.**

**Rationale**

The Committee considered the standard Medicare data and current clinical evidence for these items. In addition, it considered the relevance of these items and whether their services are currently accounted for by other items listed on the MBS. After considering these factors, the Committee agreed that:

- The Committee recommended item 32132 is deleted as item 32135 sufficiently provides for haemorrhoid or rectal prolapse treatment.
- The Committee recommended item 32138 is deleted as item 32139 sufficiently provides the haemorrhoidectomy service described by the item.
- The Committee recommended item 32153 is deleted as item 32171 sufficiently provides this procedure.
- The Committee recommended item 32168 is deleted as there are other item numbers that can be claimed for review of wounds and this item is considered non-specific.
4.7.3. Recommendation 28

Table 34: Standard Medicare data for excision of anal skin tag/anal polyps items 32142 and 32145, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32142</td>
<td>Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)</td>
<td>$67.50</td>
<td>737</td>
<td>$37,542.65</td>
<td>-2.79%</td>
</tr>
<tr>
<td>32145</td>
<td>Anal skin tags or anal polyps, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.)</td>
<td>$135.05</td>
<td>3,579</td>
<td>$217,464.08</td>
<td>4.74%</td>
</tr>
</tbody>
</table>

Recommendation: Combine items 32142 and 32145 into one item.

- The Committee recommended items 32142 and 32145 be combined into one item with the amended item descriptor for the new item to read:
  - “Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)”

- The Committee recommended the fee for the new combined item be set at an intermediate value between items 32142 and 32145 based upon service volume.

Rationale
After considering the relevance of these items in contemporary surgical management of anal skin tags or anal polyps, the Committee agreed there is no valid justification for a difference in fees to exist for these services on the basis of the setting in which the procedure is performed. Therefore, the Committee agreed these items should be combined so as to simplify and streamline the MBS.
4.7.4. Recommendation 29

Table 35: Standard Medicare data for items for anal wart removal, 32177 and 32180, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32177</td>
<td>Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)</td>
<td>$174.25</td>
<td>293</td>
<td>$32,004.35</td>
<td>2.26%</td>
</tr>
<tr>
<td>32180</td>
<td>Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)</td>
<td>$256.95</td>
<td>76</td>
<td>$12,134.40</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Recommendation: Combine items 32177 and 32180 into one item.

- The Committee recommended items 32177 and 32180 be combined into one item with the amended item descriptor for the new item to read:
  - “Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)”

Rationale

After considering the relevance of these services in contemporary surgical practice, the Committee agreed it is inappropriate to spend more than 45 minutes removing anal warts during one session. This is because this practice can create a large, raw area of skin which can be painful for the patient. The Committee agreed that, if anal wart removal of this magnitude were necessary, it would be more appropriate to perform the removal over more than one session to improve patient comfort. Therefore, the Committee agreed the current items be combined into one, with no specification of the time taken to perform the procedure.
4.7.5. Recommendation 30

Table 36: Standard Medicare data for items for the treatment of haemorrhoids, fissures and fistulae, 32135, 32139, 32150, 32156 and 32165, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32135</td>
<td>Haemorrhoids or rectal prolapse rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.)</td>
<td>$67.50</td>
<td>30,690</td>
<td>$829,292.64</td>
<td>1.85%</td>
</tr>
<tr>
<td>32139</td>
<td>Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.)</td>
<td>$367.75</td>
<td>6,277</td>
<td>$1,565,090.25</td>
<td>5.39%</td>
</tr>
<tr>
<td>32150</td>
<td>Operation for fissure in ano, including excision or sphincterotomy but excluding dilatation only (Anaes.) (Assist.)</td>
<td>$256.95</td>
<td>3,330</td>
<td>$492,097.50</td>
<td>-0.13%</td>
</tr>
<tr>
<td>32156</td>
<td>Fistula-in-ano, subcutaneous, excision of (Anaes.)</td>
<td>$131.75</td>
<td>305</td>
<td>$21,395.90</td>
<td>-2.99%</td>
</tr>
<tr>
<td>32165</td>
<td>Anal fistula, repair of by mucosal flap advancement (Anaes.) (Assist.)</td>
<td>$634.70</td>
<td>402</td>
<td>$184,249.30</td>
<td>10.68%</td>
</tr>
</tbody>
</table>

Recommendation: Amend the item descriptors for haemorrhoidectomy items 32135 and 32139, fissure items 32150 and 32156 and fistula item 32165.

The Committee recommended the item descriptors for items 32135, 32139, 32150, 32156 and 32165 be amended to more appropriately reflect the modern surgical treatment of these conditions.

- The Committee recommended the amended item descriptor for item 32135 read:
  
  “Treatment of haemorrhoids or rectal prolapse including rubber band ligation or sclerotherapy for, where 32139 does not apply (Anaes)”.

- The Committee recommended the amended item descriptor for item 32139 read:
  
  “Operative treatment of haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed, not being a service to which items 32111, 32112 or 32135 applies (Anaes) (Assist)”.

The Committee recommended the amended item descriptor for item 32150 read:

- “Operation for anal fissure, including excision or sphincterotomy, excluding dilation (Anaes) (Assist)”. 

The Committee recommended the amended item descriptor for item 32156 read:

- “Anal fistula, subcutaneous, excision of (Anaes)”. 

The Committee recommended the amended item descriptor for item 32165 read:

- “Operative treatment of anal fistula, repair by mucosal flap advancement including ligation of intersphincteric fistula tract, video-assisted tract ligation, collagen plug or stem cells (Anaes) (Assist)”. 

Rationale

The Committee recommended the items numbers for the treatment of haemorrhoids be simplified into two numbers. These are intended to reflect currently performed operative and non-operative procedures and will allow for addition of new procedures.

- Item 32135 includes all non-operative haemorrhoid treatments including rubber band ligation and sclerotherapy. 

- Item 32139 includes all forms of operative haemorrhoid treatments but excludes procedures for rectal prolapse which should not be co-claimed. 

Additionally, the Committee recommended the wording of the descriptor for item 32150 be changed from ‘fissureinano’ to ‘anal fissure’ to reflect more contemporary nomenclature.

Similarly, the Committee recommended the wording of the descriptors for items 32156 and 32165 be changed from ‘fistulainano’ to ‘anal fistula’ to reflect more contemporary nomenclature. 

4.8. Graciloplasty items

Graciloplasty is a surgical procedure in which the gracilis muscle is transposed into the anus for the treatment of intractable faecal incontinence. The muscle is implanted along with an electrode from an electric pulse generator.

The Committee reviewed four graciloplasty items. 

The Committee recommends that all graciloplasty items are deleted from the MBS.
4.8.1. Recommendation 31

Table 37: Standard Medicare data for graciloplasty items 32200, 32203, 32206 and 32209, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32200</td>
<td>Distal muscle, devascularisation of (Anaes.) (Assist.)</td>
<td>$295.70</td>
<td>2</td>
<td>$443.60</td>
<td>-</td>
</tr>
<tr>
<td>32203</td>
<td>Anal or perineal graciloplasty (Anaes.) (Assist.)</td>
<td>$635.00</td>
<td>1</td>
<td>$476.25</td>
<td>-</td>
</tr>
<tr>
<td>32206</td>
<td>Stimulator and electrodes, insertion of, following previous graciloplasty (Anaes.) (Assist.)</td>
<td>$573.70</td>
<td>2</td>
<td>$645.45</td>
<td>-</td>
</tr>
<tr>
<td>32209</td>
<td>Anal or perineal graciloplasty with insertion of stimulator and electrodes (Anaes.) (Assist.)</td>
<td>$921.95</td>
<td></td>
<td></td>
<td>-100.00%</td>
</tr>
</tbody>
</table>

Recommendation: Delete all graciloplasty items.

Rationale

The Committee noted the extremely low service volumes for these items. The Committee agreed that, since the introduction of sacral neuromodulation, graciloplasty is no longer considered as the best surgical approach for management of faecal incontinence. The procedure carries considerable risk of complications including pain, infection of the surgical site or issues with the electronic device. Therefore, the service should not be funded under the MBS and should be deleted due to concerns about patient safety.

4.9. Sacral nerve lead items

Sacral nerve stimulation (also called sacral neuromodulation) is used in the treatment of faecal incontinence. Placement of a neurostimulator delivers electrical stimulation to a sacral nerve, which can improve continence.

The Committee reviewed seven items related to the placement, replacement and removal of sacral nerve leads.

The Committee recommended that:

- Three sacral nerve items be combined; and
- The descriptors of four items be amended.
The Committee considered co-claiming data for items related to the placement, programming and removal of sacral nerve stimulators or leads and agreed some of these items could be combined into a complete medical service. There were nine instances during FY2016/17 where items 32213, 32214, 32215, 32217 and 32218 were co-claimed together in the one episode (see Table 38).

**Table 38: Co-claiming of sacral nerve items, 2016/17.**

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
</tr>
</thead>
</table>
| 32213 | Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who:  
   a) has an anatomically intact but functionally deficient anal sphincter; and  
   b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;  
   other than a patient who:  
   c) is medically unfit for surgery; or  
   d) is pregnant or planning pregnancy; or  
   e) has irritable bowel syndrome; or  
   f) has congenital anorectal malformations; or  
   g) has active anal abscesses or fistulas; or  
   h) has anorectal organic bowel disease, including cancer; or  
   i) has functional effects of previous pelvic irradiation; or  
   j) has congenital or acquired malformations of the sacrum; or  
   k) has had rectal or anal surgery within the previous 12 months (Anaes.) | $660.95 |
| 32214 | Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who:  
   a) has an anatomically intact but functionally deficient anal sphincter; and  
   b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who:  
   c) is medically unfit for surgery; or  
   d) is pregnant or planning pregnancy; or  
   e) has irritable bowel syndrome; or  
   f) has congenital anorectal malformations; or  
   g) has active anal abscesses or fistulas; or  
   h) has anorectal organic bowel disease, including cancer; or  
   i) has functional effects of previous pelvic irradiation; or  
   j) has congenital or acquired malformations of the sacrum; or  
   k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.) | $334.00 |
| 32215 | Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:  
   a) is medically unfit for surgery; or  
   b) is pregnant or planning pregnancy; or | $125.40 |
Item | Descriptor | Schedule fee |
--- | --- | --- |
| c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months – each day |
32217 | Neurostimulator or receiver, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) | $156.30 |
32218 | Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) | $156.30 |

4.9.1. Recommendation 32

Table 39: Standard Medicare data for sacral nerve items 32210, 32214 and 32217, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32210</td>
<td>Gracilis neosphincter pacemaker, replacement of (Anaes.)</td>
<td>$255.45</td>
<td>4</td>
<td>$791.95</td>
<td>-10.59%</td>
</tr>
</tbody>
</table>
### Item 32214

**Descriptor**: Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who:

- a) has an anatomically intact but functionally deficient anal sphincter; and
- b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who:
  - c) is medically unfit for surgery; or
  - d) is pregnant or planning pregnancy; or
  - e) has irritable bowel syndrome; or
  - f) has congenital anorectal malformations; or
  - g) has active anal abscesses or fistulas; or
  - h) has anorectal organic bowel disease, including cancer; or
  - i) has functional effects of previous pelvic irradiation; or
  - j) has congenital or acquired malformations of the sacrum; or
  - k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.)

**Schedule fee**: $334.00

**Services FY2016/17**: 306

**Benefits FY2016/17**: $54,717.45

**Services 5-year annual avg. growth**: 8.55%

### Item 32217

**Descriptor**: Neurostimulator or receiver, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.)

**Schedule fee**: $156.30

**Services FY2016/17**: 128

**Benefits FY2016/17**: $9,385.35

**Services 5-year annual avg. growth**: 23.81%

---

**Recommendation: Combine sacral nerve items 32210, 32214 and 32217 into one item.**

The Committee recommended items 32210, 32214 and 32217 be combined into one item with the item descriptor of the combined item to read:

“Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence (Anaes.) (Assist.)”.
Rationale

Public funding through the MBS for sacral nerve stimulation has been available since 2005. At that time, there was a lack of evidence for the effectiveness of sacral nerve stimulation in patients with sphincter defects. Since 2005 there has been an increased evidence base for

The Committee recommended the removal of the 12 month patient waiting period from the descriptor of the combined item as patients have often undergone a period of non-operative management before getting to the point of referral to a colorectal surgical specialist for consideration for stimulation and will have already endured a lengthy period of faecal incontinence.

The previous wording within items 32214 and 32217 ‘anatomically intact but functionally deficient’ are recommended for removal from the new combined item descriptor as evidence indicates clinical validity outside this requirement (9) (10) (11) (12) (13).
4.9.2. Recommendation 33

Table 40: Standard Medicare data for sacral nerve items 32213, 32215, 32216 and 32218, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32213</td>
<td>Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Aaes.)</td>
<td>$660.95</td>
<td>445</td>
<td>$220,537.33</td>
<td>2.78%</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Schedule fee</td>
<td>Services FY2016/17</td>
<td>Benefits FY2016/17</td>
<td>Services 5-year annual avg. growth</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>32215</td>
<td>32215 Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months—each day</td>
<td>$125.40</td>
<td>1,465</td>
<td>$141,098.55</td>
<td>13.58%</td>
</tr>
<tr>
<td>32216</td>
<td>32216 Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Aaes.)</td>
<td>$593.55</td>
<td>28</td>
<td>$12,464.85</td>
<td>28.47%</td>
</tr>
<tr>
<td>Item</td>
<td>Descriptor</td>
<td>Schedule fee</td>
<td>Services FY2016/17</td>
<td>Benefits FY2016/17</td>
<td>Services 5-year annual avg. growth</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>32218</td>
<td>Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.)</td>
<td>$156.30</td>
<td>85</td>
<td>$4,687.90</td>
<td>18.10%</td>
</tr>
</tbody>
</table>

Recommendation: Amend the item descriptors for sacral nerve items 32213, 32215, 32216 and 32218.

- The Committee recommended the item descriptor for item 32213 be amended to read:
  - “Sacral nerve lead(s), placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence. Contraindicated in:
    - **(a)** patients under 18 years of age; and
    - **(b)** patients 18 years of age or older who:
      - **(i)** are pregnant or planning pregnancy; or
      - **(ii)** have untreated perianal sepsis or malignancy.

- The Committee recommended the item descriptor for item 32215 to read:
o “Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:

(a) patients under 18 years of age; and

(b) patients 18 years of age or older who:

(i) are pregnant or planning pregnancy; or

(ii) have untreated perianal sepsis or malignancy. (Anaes.)

Not to be claimed more than once per day by the same practitioner. Not being a service associated with a service to which items 32213, 32214, 32216, 32217 or 32218 applies.”

• The Committee recommended the item descriptor for item 32216 be amended to read:

  o “Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.)”

• The Committee recommended the item descriptor for item 32218 be amended to read:

  o “Sacral nerve lead or leads, removal (Anaes.)”

Rationale

The previous restrictions on the use of sacral nerve stimulation were provided by the initial clinical trial in order to minimise heterogeneity. However, published evidence supports the use of SNS in these patients with significant clinical benefit and improved quality of life.

4.10. Diagnostic item

The Committee reviewed one diagnostic procedure used in the diagnosis of abnormalities of the pelvic floor.
4.10.1. Recommendation 34

Table 41: Standard Medicare data for diagnosis of abnormalities of the pelvic floor, item 11833, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>11833</td>
<td>DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency</td>
<td>$249.75</td>
<td>3,304</td>
<td>$692,054.75</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Recommendation: Leave diagnostic item 11833 unchanged.

Rationale:

After considering the standard Medicare data and contemporary clinical evidence associated with this service, the Committee agreed the item should be left unchanged. This is because:

- This item adequately describes the procedure.
- The procedure reflects current best practice.
- The procedure is not provided under other items.
- There is unlikely to be misuse of these items.

4.11. Ungrouped colorectal surgery items

The Committee reviewed nine ungrouped colorectal surgery items.

The Committee recommended that within this group:

- Five items remain unchanged;
- Three items be deleted; and
- The descriptors of one item be amended.
4.11.1. Recommendation 35

Table 42: Standard Medicare data for ungrouped colorectal surgery items 32036, 32047, 32183, 32186 and 32212, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32036</td>
<td>Sacrococcygeal and presacral tumour excision of (Anaes.) (Assist.)</td>
<td>$1,911.80</td>
<td>82</td>
<td>$98,287.35</td>
<td>9.54%</td>
</tr>
<tr>
<td>32047</td>
<td>Perineal proctectomy (Anaes.) (Assist.)</td>
<td>$871.30</td>
<td>17</td>
<td>$9,088.35</td>
<td>-5.03%</td>
</tr>
<tr>
<td>32183</td>
<td>Intestinal sling procedure prior to radiotherapy (Anaes.) (Assist.)</td>
<td>$561.65</td>
<td>15</td>
<td>$2,843.85</td>
<td>-7.37%</td>
</tr>
<tr>
<td>32186</td>
<td>Colonic lavage, total, intraoperative (Anaes.) (Assist.)</td>
<td>$561.65</td>
<td>96</td>
<td>$25,201.75</td>
<td>1.08%</td>
</tr>
<tr>
<td>32212</td>
<td>Ano-rectal application of formalin in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.)</td>
<td>$136.25</td>
<td>68</td>
<td>$4,731.45</td>
<td>-13.32%</td>
</tr>
</tbody>
</table>

**Recommendation:** Leave colorectal surgery items 32036, 32047, 32183, 32186 and 32212 unchanged.

**Rationale**

The Committee considered the relevance of the service associated with item 32036. The Committee agreed this item represents an isolated resection to remove tumours and is generally not performed with other procedures.

Item 32183 is a rarely performed procedure used for the treatment of gynaecological cancers. While infrequently used, this procedure remains relevant in contemporary surgical management of some conditions and is recommended to remain unchanged.

The Committee noted:

- The items adequately describe the procedures.
- The procedures are reflective of current best practice.
- The procedures are not provided under other items.
- There is unlikely misuse of these items.
4.11.2. Recommendation 36

Table 43: Standard Medicare data for ungrouped colorectal surgery items 32029, 32220 and 32221, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32029</td>
<td>Colonic reservoir, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.)</td>
<td>$421.20</td>
<td>218</td>
<td>$27,576.80</td>
<td>-9.09%</td>
</tr>
<tr>
<td>32220</td>
<td>Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)</td>
<td>$903.90</td>
<td>3</td>
<td>$2,033.80</td>
<td>24.57%</td>
</tr>
<tr>
<td>32221</td>
<td>Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)</td>
<td>$903.90</td>
<td>0</td>
<td>0</td>
<td>-100.00%</td>
</tr>
</tbody>
</table>

Recommendation: Delete colorectal surgery items 32029, 32220 and 32221.
Rationale

The Committee recommended that item 32029 (construction of a colonic reservoir) be deleted and the service described by this item be included within the descriptors for items 32026 and 32028. Items 32026 and 32028 are both rectal resection procedures used in the treatment of rectal cancer. The construction of a colonic reservoir has been shown to result in improved postoperative functioning of the rectum by decreasing rates of faecal urgency and incontinence (14).

It is recommended that item 32029 be deleted as a separate item for the construction of a colonic reservoir is no longer required if the recommended amendments to the descriptors for items 32026 and 32028 to include ‘with or without colonic reservoir’ are adopted.

- The fee for the combined item should be set at a value proportional to service volumes for items 32026 and 32029, and 32028 and 32029.

The Committee recommended the deletion of items 32220 and 32221 as artificial bowel sphincters are no longer considered best practice for the treatment of severe faecal incontinence. This is due to the high rates of complications associated with artificial bowel sphincters.

The need for a specific MBS item for the removal or revision of artificial bowel sphincters has become negated as it is presumed that all previously inserted artificial bowel sphincters have now been removed.

4.11.3. Recommendation 37

Table 44: Standard Medicare data for ungrouped colorectal surgery item 32171, 2016/17.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
<th>Schedule fee</th>
<th>Services FY2016/17</th>
<th>Benefits FY2016/17</th>
<th>Services 5-year annual avg. growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>32171</td>
<td>Anorectal examination, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.)</td>
<td>$88.80</td>
<td>1,176</td>
<td>$76,329.25</td>
<td>1.46%</td>
</tr>
</tbody>
</table>

Recommendation:

Amend the item descriptor for colorectal surgery item 32171.

- The Committee recommended the item descriptor for item 32171 be amended to read:
“Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, not being a service associated with a service to which another item in this Group applies (Anaes.)”

Rationale

The Committee recommends that the addition of ‘with or without faecal disimpaction’ to item 32171. Currently, this procedure is included within item 32153, however item 32153 is recommended for deletion.

4.12. Peritonectomy

Peritonectomy is a surgical procedure to remove peritoneal mitotic disease. This is most commonly applied to pseudomyxoma peritonei and to peritoneal colorectal cancer, but may also be applied to patients with peritoneal mesothelioma.

Cytoreductive surgery is performed during the peritonectomy to enable removal all the visible tumour within the peritoneal cavity. This may involve resection of a number of organs as well as stripping of wide areas of peritoneum, including subdiaphragmatic, to optimise the ability to remove all disease. Cytoreductive surgery is usually combined with hyperthermic intraperitoneal chemotherapy (HIPEC), which is delivered to the peritoneal cavity during the operation, as a component of the operative procedure, to maximise the likelihood of elimination of all the tumour cells and minimise the risk of recurrence.

Currently, there are no MBS items for peritonectomy. The Committee considered how peritonectomy could best be incorporated into MBS items, particularly in regards to compliance with proposed three item rule.

4.12.1. Recommendation 38

Table 45: Proposed new peritonectomy items recommended for creation.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>320MM</td>
<td>Peritonectomy less than 5 hours, including hyperthermic intra-peritoneal chemotherapy.</td>
</tr>
<tr>
<td>320NN</td>
<td>Peritonectomy greater than 5 hours, involving multiviscera, including hyperthermic intra-peritoneal chemotherapy.</td>
</tr>
</tbody>
</table>

Recommendation: Create two new peritonectomy items.

Rationale

Peritonectomy and HIPEC is now an established procedure and is undertaken at a limited number of specialist centres (one in each state and two in New South Wales) across Australia. It is now included as part of the current National Health and Medical Research
Council (NHMRC) clinical practice guidelines for the prevention, early detection and management of colorectal cancer (15). The surgery usually involves radical resection of a number of organs as well as removal of areas of peritoneum, with the aim to clear disease (16) (17). While MBS item 30392 exists for debulking of advanced intra-abdominal malignancy and item 35720 for debulking of advanced gynaecological malignancy, there are currently no numbers that represent the extensiveness of peritonectomy surgery.

The Committee recommends the new peritonectomy items are time-based, with time referring to operative time only, not overall theatre utilisation time. This is in view of the wide spectrum of potential individual procedures that can be undertaken in combination (e.g. right hemicolecetomy, small bowel resection, anterior resection, abdominal hysterectomy, bilateral oophorectomy, splenectomy, cholecystectomy, peritonectomy [pelvic, flank, right and left subdiaphragmatic], greater and lesser omentectomy, partial gastrectomy), as well as the application of Hyperthermic intraperitoneal chemotherapy (HIPEC) (18) (19) (20). A time-based model is proposed as these procedures hold some similarity to the time-based items for division of adhesions. This is due to the fact that the extent of the operation, with respect to the number of individual procedures required, is proportional to the amount of disease present, and total clearance of the disease present in the abdomen, rather than just debulking of the disease, is essential to ensure optimal outcomes. As the multiple procedures required cannot be included within three numbers only, a time based approach would give a more realistic representation of the workload required for any specific operation.

Excellent outcomes can be obtained from peritonectomy and HIPEC, with the specific outcomes strongly dependent on the tumour type and the extent of disease present. Five year survival for pseudomyxoma peritonei is over 70%, with both low and high volume cases appropriate for surgery. This is in contrast to colorectal cancer, where surgery is restricted to cases with lower disease volume, as commonly measured using the the Peritoneal Cancer Index as being disease volume less than 15/39. In these cases, a 5 year survival of 35-40% is attainable, as compared to a 6-12 month overall survival with chemotherapy alone.

### 4.13. Pelvic exenteration

Multivisceral resections are performed for advanced primary pelvic malignancies including colorectal and anal cancers, selected gynaecological or urological cancers, as well as recurrent pelvic cancers.

Pelvic exenteration operations vary widely in magnitude from more straight forward, centrally-placed resections (e.g. en bloc resection of a uterus or part of a bladder, at the same time of a rectal or sigmoid cancer resection which could be performed in most larger
hospitals) to major exenterations which include resection of the rectum, sphincters, pelvic floor, bladder and prostate or uterus and vagina.

More extensive exenterations may also include the pelvic side wall vasculature as well as lymph nodes and/or bony structures surrounding the pelvis including sacrum, ischium or pubic bones. The complexity of the surgery increases with surgery for recurrent tumours. Major exenterations may typically require nine to 12 hours of operating time, but can take in excess of 16 hours. These patients have an average length of hospital stay between three and four weeks. Major exenterations should be performed in specialist referral centres.

Co-morbidities such as inflammatory bowel disease add further complexity to these procedures.

A subgroup was formed within the Committee to consider how best to address pelvic exenterations in order to develop items which describe a complete medical service. Data was provided by three specialist referral units where such surgeries are performed. A total of 80 cases were provided for analysis of MBS services data. No common theme was deduced due to the high variability of surgeries, heterogeneity in the length of surgery and lack of clear patterns in billing codes.

Surgeons undertaking pelvic exenterations within the data observed all claimed in excess of three MBS items and frequently claimed between 10 and 20 items for the one procedure.

For these reasons, the Committee has proposed three new items number for pelvic exenteration based upon the extensiveness of the procedure.

4.13.1. Recommendation 39

Table 46: Proposed new pelvic exenteration items based upon anatomical compartment.

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>320PP</td>
<td>Pelvic exenteration involving en bloc soft tissue multivisceral resection (excluding en bloc hysterectomy and colorectal resection) performed at an appropriately resourced major specialist centre for advanced pelvic cancer</td>
</tr>
<tr>
<td>320QQ</td>
<td>Pelvic exenteration involving en bloc bony multivisceral resection performed at an appropriately resourced major specialist centre for treatment of advanced pelvic cancer (excluding coccygectomy, i.e. bony resection should involve en bloc resection of major bony structure such as sacrectomy or resection of pubic bones or ischium)</td>
</tr>
<tr>
<td>320RR</td>
<td>Pelvic exenteration involving en bloc resection of pelvic side wall major vasculature with nodal tissue, pelvic fascia and or obturator internus muscle performed at an appropriately resourced major specialist centre for advanced pelvic cancer</td>
</tr>
</tbody>
</table>
Recommendation: Create three new items for pelvic exenteration based upon anatomical compartments.

Rationale

The three proposed new items are based upon how extensive the exenteration is in regards to the extent of viscera, bony structure and vasculature involved. The number of new items could be further increased if the procedures were divided by primary or recurrent pelvic cancer as this would more accurately reflect the complexity of the surgery. This would create the need for six new items, rather than only the three recommended in Table 42.

The fees for these items should reflect the complexity and be well remunerated commensurate with the expected complexity of the procedure and its aftercare. However, the Committee raised concerns about possible misuse of these item numbers due to high remuneration. Therefore the proposed new items specify that these procedures should be performed in major specialist referral units, of which there is typically only one per state (and none in the smaller states or Territories).

Major exenterations involve multiple surgeons who should be able to claim these numbers. Currently most major exenterations involve two surgical teams but can involve colorectal surgeons, urologists, vascular surgeons, plastic surgeons and orthopaedic oncologists.


A stoma is constructed by bringing a portion of everted intestine with its blood supply to the exterior of the abdomen. Urinary stomas have the renal ureters secured to the portion of intestine. Faecal stomas can begin at various stages in the colon and may be loop or terminal-type stomas. The urine or faeces is collected in stomal appliance bags that are secured to the skin with compatible adhesive backing, and a range of other specialised products supplied through the Stoma Appliance Scheme are also required. A stoma may be required for conditions such as colorectal, urological or gynaecological cancer, Crohn’s disease and other inflammatory bowel diseases, in cases of intractable faecal incontinence and in some congenital conditions (colostomy, ileostomy, or urostomy).

A stoma may be temporary or permanent, with both requiring new skills to be learnt and physical, social and emotional adjustments to be made. Stomal Therapy Nurses have undertaken specialist education and training to help patients manage these changes.

There is wide disparity in patient access to stomal therapy nursing services across Australia. It can be more difficult for private hospital patients and for patients in regional and remote areas to access stomal therapy services, particularly following discharge from hospital. Access to services is further impaired by a shortage of nurses with sufficient stomal therapy
qualifications. This can compromise appropriate care for patients who have had ostomy surgery and impact on the patient’s physical, social and emotional outcomes.

Timely access to Stomal Therapy nursing services can greatly assist patients who will undergo elective or emergency colorectal or urinary diversion. Preoperative consultations can help in establishing optimal placement of the stoma, considering body habitus and the patient’s capacities. Stomal Therapy Nursing services result in shorter hospital stays and decreased readmissions arising from complications of product adhesion, wound breakdown or the understandable anxiety as a result of a significant change in bodily function.

Recommendations

- That the Explanatory Notes for items 32025, 32026 and 32028 be amended to state that these procedures should be performed in a setting with adequate access to stomal therapy nurse services.

- Consider creating new items for services provided by stomal therapy nurses, who deliver specialised care for patients with a stoma. Services that are currently provided by stomal therapy nurses include management of faecal or urinary diversions, management of wounds, fistulae, and gastronomies, continence advice and pre and post-operative counselling.

- That the Government considers what additional steps could be taken to ensure that the extent and nature of the work performed by stomal therapy nurses is captured by the MBS. The Committee acknowledges that this is a complex policy space that warrants detailed consideration.

Rationale

The recommendations focus on improving access to care and are based on the following observations (21) (22) (23) (24) (25) (26):

- The Committee noted that stomal therapy nurses play an important role in the provision of care for patients living with either a temporary or permanent stoma. A stoma is often as a result of bowel surgery due to conditions such as colorectal, urological or gynaecological cancer, Crohn’s disease and other inflammatory bowel diseases, or may be created due to trauma to the abdomen, congenital abnormalities, neurological disorders, degenerative changes in the bowel’s blood supply, or after-effects of some radiation therapies. There are currently estimated to be 44,000 people in Australia living with a stoma.

- Stomal therapy nurses have undertaken specialist education to achieve an advanced level of theoretical knowledge and clinical skills through programs offered at educational or hospital-based facilities. Stomal therapy nurses hold a Graduate
Certificate or a Certificate recognized by the Australian Health Practitioner Regulation Agency and the Australian Association of Stomal Therapy Nurses. Stomal therapy nurses, as well as the treating surgeons, assist patients to access stomal therapy products available under the Australian Government Stoma Appliance Scheme. At the present time, there is no provision within the MBS for stomal therapy services.

- Currently, there is wide disparity in access to services provided by stomal therapy nurses across Australia. It is often more difficult for private hospital patients and for patients in regional and remote areas to access stomal therapy services, particularly following discharge from hospital. Access to services is further impaired by a shortage of nurses with sufficient stomal therapy qualifications. This may compromise appropriate care for patients who have had ostomy surgery and impact on the patient’s physical, social and emotional outcomes.

4.15. Enhanced Recovery after Surgery (ERAS)

Recommendations

- Amend the Explanatory Notes of MBS items 32000, 32003, 32004, 32005, 32009, 32012, 32015, 32018, 32021, 32024, 32025, 32026 and 32028 to include advice that for these procedures, the patient should be managed utilising ERAS principles where appropriate.

- Recommend that the MBS Review Taskforce consider providing advice to the Department of Health suggesting the need for ERAS protocols to be incorporated into the Explanatory Notes of all suitable surgical procedures including colorectal, orthopaedic, urological and pancreatic surgeries.

Rationale

Enhanced recovery after surgery (ERAS) (fast-track) programs are comprehensive multimodal perioperative pathways, which aim to reduce surgical stress, maintain postoperative physiological function, and enhance mobilisation after surgery (27) (28).

These recommendations seek to optimise recovery for surgical patients through decreased length of hospital stay, faster restoration of gut function, reduced morbidity and an early return to normal activities among colorectal surgery patients (27) (28).

ERAS protocols are applied via multidisciplinary pathways, encompassing peri- and postoperative elements, including:

- Education and counselling;
• Perioperative focus on improved well-being through:
  o Exercise;
  o Nutrition;
  o Cessation of smoking; and
  o Perioperative nutritional supplements.

• Avoidance of bowel preparation, nasogastric tubes and drains.

• Appropriate medication, including:
  o Multimodal antiemetics;
  o Multimodal analgesia;
  o Venous thromboembolism prophylaxis; and
  o Prophylactic antibiotics.

• Early postoperative mobilization.

• Early postoperative nutrition.

• Early return to normal activities.

4.16. Consumer Health Literacy

Recommendations

• The Committee supported the recommendations of the Specialist and Consultant Physicians Consultations Clinical Committee of the MBS Review; Recommendation 10: Improve patient consent and shared decision-making.

• The Committee endorses best clinical practice in line with the Royal College of Surgeons’ Position Paper: Informed Consent and emphasises the need for patient access to appropriate and readily understandable information about treatment options, associated risks and the expected outcomes (29).

• The Committee encourages increased patient education of available resources such as those available through the Colorectal Surgical Society of Australia and New Zealand (30).
Rationale

The Committee emphasises the importance of consumers being well supported when considering undergoing colorectal surgery procedures. This support is given through patient education that enables the consumer to give informed consent prior to a procedure being performed. Over 50% of Australian adults do not have a level of health literacy needed to understand health information (31). This can influence health care decisions, with low levels of health literacy associated with undesirable health outcomes such as low participation in preventative programs and poor medication adherence (32).

The Committee considers that consultation with a colorectal surgeon should include the provision of appropriate written and visual material that accurately describes the procedure, alternative options where possible, and information regarding the patient’s medical condition. Provision of educational materials helps to improve consumer understanding and allows for accurate information to be conveyed to carers and family members.
5. Impact statement

This section of the report summarises the Committee’s recommendations in plain English and is intended to support and encourage consumers to comment on the recommendations.

Both consumers and clinicians are expected to benefit from the Committee’s recommendations as they address concerns regarding consumer safety and quality of care and take steps to simplify the MBS to make it easier to use and understand. Consumer access to services was considered for each recommendation. The Committee also considered the impact of each recommendation on provider groups to ensure that changes were reasonable and fair. However, if the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.

The Committee expects these recommendations will support the provision of appropriate colorectal surgery services that incorporate clinically indicated, high-quality surgical methods and techniques that reflect modern best practice.

The Committee’s recommendations for the deletion of 16 items are expected to benefit consumers by reducing the overall number of colorectal surgery MBS items, thereby making the MBS simpler and, for providers, more user-friendly. In most cases, recommendations to delete items relate to procedures that are appropriately performed as an intrinsic part of another procedure. However where an item is always performed as part of another procedure and there is no other clinical indication for its use as a standalone item, the Committee recommended its deletion. For example, item 32006 for hemicolectomy (removal of part of the bowel) was recommended for deletion as the same service is always performed with either the creation of a stoma (where an opening is made to connect the end of the bowel with the surface of the abdomen) or an anastomosis (where one part of the bowel is connected to another part) so there is no clinical need for an item for hemicolectomy alone. The services patients receive will not be affected by this change.

Some items are recommended for deletion because the procedure described by the item is no longer considered best practice. In these instances, the Committee recommended the deletion of services based upon patient safety concerns. For example, the Committee recommended the deletion of items for gracilioplasty, a procedure in which a muscle from the inner thigh is surgically moved to the anus as a treatment for faecal incontinence. Deletion of gracilioplasty items is recommended because this is no longer considered the best way of surgically treating patients with faecal incontinence and may be associated with pain and other complications. Patients will benefit from this change because the best services, according to recent clinical evidence, will be available on the MBS.
The new services recommended by the Committee are intended to reflect surgical techniques not previously covered by the MBS. These are for procedures that are already being performed and there is good evidence that they have the best outcomes for patients. Having specific item numbers for these new surgical procedures provides better transparency when billing the consumer because the service will be properly described by the relevant item number, rather than using an item number for the equivalent older service. The new items will also provide more appropriate Medicare rebates which are expected to reduce the out-of-pocket costs to consumers associated with these procedures.

Some of the new items recommended by the committee are for complex surgeries which previously were performed but were billed under a variety of ‘best fit’ items. Now they have their own item descriptor and number. This will benefit patients as it will improve the consistency of billing across providers and make it clearer to the patient what service they have received.

Additional recommendations to amend the descriptors of items and to combine items that provide a similar service, will help to create a much simpler colorectal surgery portion of the MBS that more accurately describes current best clinical practice.

The Committee's recommendations around access to stomal therapy nursing, ERAS and consumer health literacy, draw attention to, and are intended to initiate change regarding, important consumer health issues for patients who require colorectal surgery.
6. References

This contains references to sources and materials referenced in this report.


## 7. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGR</td>
<td>Compound annual growth rate or the average annual growth rate over a specified time period.</td>
</tr>
<tr>
<td>Change</td>
<td>When referring to an item, ‘change’ describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).</td>
</tr>
<tr>
<td>CSSANZ</td>
<td>Colorectal Surgical Society of Australia and New Zealand</td>
</tr>
<tr>
<td>Delete</td>
<td>Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.</td>
</tr>
<tr>
<td>Department, The</td>
<td>Australian Government Department of Health</td>
</tr>
<tr>
<td>DHS</td>
<td>Australian Government Department of Human Services</td>
</tr>
<tr>
<td>FAP</td>
<td>Familial adenomatous polyposis</td>
</tr>
<tr>
<td>FY</td>
<td>Financial year</td>
</tr>
<tr>
<td>High-value care</td>
<td>Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.</td>
</tr>
<tr>
<td>IBD</td>
<td>Inflammatory bowel disease</td>
</tr>
<tr>
<td>HIPEC</td>
<td>Hyperthermic intraperitoneal chemotherapy</td>
</tr>
<tr>
<td>Inappropriate use / misuse</td>
<td>The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Low-value care</td>
<td>Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MBS item</td>
<td>An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.</td>
</tr>
<tr>
<td>MBS service</td>
<td>The actual medical consultation, procedure or test to which the relevant MBS item refers.</td>
</tr>
<tr>
<td>MIS</td>
<td>Minimally invasive surgical approach</td>
</tr>
<tr>
<td>Misuse (of MBS item)</td>
<td>The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.</td>
</tr>
<tr>
<td>MSAC</td>
<td>Medical Services Advisory Committee</td>
</tr>
<tr>
<td>New service</td>
<td>Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>No change or leave unchanged</td>
<td>Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).</td>
</tr>
<tr>
<td>Obsolete services / items</td>
<td>Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>Services average annual growth</td>
<td>The average growth per year, over five years to 2016/17, in utilisation of services. Also known as the compound annual growth rate (CAGR)</td>
</tr>
<tr>
<td>taTME</td>
<td>Transanal total mesorectal excision</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Committee</td>
<td>The Colorectal Surgery Clinical Committee of the MBS Review</td>
</tr>
<tr>
<td>The Taskforce</td>
<td>The MBS Review Taskforce</td>
</tr>
<tr>
<td>TME</td>
<td>Total mesorectal excision</td>
</tr>
<tr>
<td>Total benefits</td>
<td>Total benefits paid, data relates to the 2016/17 financial year, unless otherwise specified</td>
</tr>
</tbody>
</table>
Appendix A: Summary for consumers

The following tables describe the colorectal surgery service, the recommendations of the clinical experts and why the recommendations have been made.

**Hemicolectomy, total colectomy, and rectal resection**

**Recommendation 1**

<table>
<thead>
<tr>
<th>Items</th>
<th>What it does</th>
<th>Committee recommendation</th>
<th>What would be different</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32000, 32003, 32009, 32012 and 32015</td>
<td>Removal of either part (hemicolecotomy) or all (total colectomy) of the large bowel or rectum (rectal resection). This may involve the creation of a stoma, which is when part of the large bowel is brought up to an opening onto the abdomen to allow the passage of stool into a colostomy bag. These procedures are most often done for the treatment of bowel cancer, diverticulitis, polyps or inflammatory bowel disease.</td>
<td>Leave five items for hemicolectomy, total colectomy and rectal resection unchanged.</td>
<td>There would be no change to the current items.</td>
<td>The current items reflect best practice and do not need to be changed.</td>
</tr>
</tbody>
</table>

**Recommendation 2**

<table>
<thead>
<tr>
<th>Items</th>
<th>What it does</th>
<th>Committee recommendation</th>
<th>What would be different</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32006</td>
<td>Removal of the left part of the bowel (left hemicolectomy).</td>
<td>Delete the item.</td>
<td>Instead of being provided under this item, the procedure would be provided using a different item number which better describes the way the procedure is done in modern practice. The procedure itself would not change.</td>
<td>The way this operation is performed has evolved over time and this item has become out of date. Deleting it will make the MBS simpler and easier to use. Consumers will not be affected by the change.</td>
</tr>
</tbody>
</table>
### Recommendation 3

<table>
<thead>
<tr>
<th>Items</th>
<th>What it does</th>
<th>Committee recommendation</th>
<th>What would be different</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32004 and 32005</td>
<td>Removal of a large portion, but not all, of the large bowel. This can be done either with or without the formation of an anastomosis (where the cut end of the bowel is joined up with another part of the bowel).</td>
<td>The descriptors be changed to remove mention of item 32006 (as this has been recommended for deletion) and add a restriction that says the items cannot be claimed at the same time as item 32030.</td>
<td>When a surgeon performs an operation to remove most of the large bowel, they will only be able to claim one of these items and not item 32030. The procedure itself would not change.</td>
<td>It would be inappropriate to claim these items together as they cover similar procedures. Consumers will not be affected by the change.</td>
</tr>
</tbody>
</table>

### Recommendation 4

<table>
<thead>
<tr>
<th>Items</th>
<th>What it does</th>
<th>Committee recommendation</th>
<th>What would be different</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32024, 32025, 32026, 32028, 32030 and 32033</td>
<td>Removal of part of the rectum (the lowest part of the large bowel) with or without the creation of an anastomosis (a surgical connection that joins the cut end of the bowel to another part of the bowel) and with or without the formation of a stoma (where the bowel is connected to the abdominal wall so that it opens onto the outside of the abdomen and the stool is collected in a specialised stoma bag).</td>
<td>That the descriptors for items 32024 and 32025 be changed so that they cannot be claimed at the same time as (co-claimed) with items 32000 or 32030. It is also recommended that item 32026 be amended so the item cannot be co-claimed with items 32000, 32030, 32103, 32104, 32106 and 32117. It is also recommended Explanatory Notes be added to the items to guide appropriate use.</td>
<td>When these procedures are performed, the surgeon would not be able to claim the items at the same time as other items where co-claiming has been restricted. The procedure itself would not change.</td>
<td>The changes would ensure the appropriate procedure is claimed for the circumstances. The addition of Explanatory Notes will help guide the way the procedures are performed (e.g. at an appropriate facility and with the appropriate post-operative support).</td>
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</table>
### Synchronous surgeries

#### Recommendation 5

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>32018 and 32021</td>
<td>Removal of the large bowel and rectum with formation of an ileostomy (where the last part of the small bowel is connected to the abdominal wall and an opening formed), performed by two surgeons where one operates from the abdomen and one operates from the bottom (perineal) end.</td>
<td>That the fee for item 32018 be reduced and the fee for item 32021 be increased. It was also recommended the item descriptor amended to include use of a digital viewing platform which gives the surgeon a better view while they are operating.</td>
<td>When the large bowel is removed by two surgeons, the fee claimed by the surgeon operating from the top (abdominal surgeon) would be reduced and the fee claimed by the surgeon operating from the bottom (perineal surgeon) would be increased, relative to the current fees.</td>
<td>With new surgical techniques, the more difficult part of the surgery is now performed by the perineal surgeon rather than the abdominal surgeon. This part of the surgery requires extra training and can take more time to perform. The recommended changes to the descriptors aim to align the items and their associated fees with current surgical practices.</td>
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With new surgical techniques, the procedure itself would not change, however the new items will provide more appropriate Medicare rebates which are expected to reduce the out-of-pocket costs to consumers associated with these procedures.
### Recommendation 6

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<tr>
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<tbody>
<tr>
<td>32042 and 32045</td>
<td>Removal of part of the rectum and anus performed by two surgeons where one operates from the abdomen and one operates from the perineal end.</td>
<td>That the fee for item 32042 be reduced and the fee for item 32045 be increased. It was also recommended the item descriptors be amended to include use of a digital viewing platform.</td>
<td>When the patient’s rectum and anus are removed by two surgeons, the fee claimed by the abdominal surgeon would be reduced and the fee claimed by the perineal surgeon would be increased relative to the current fees. The procedure itself would not change, however the new items will provide more appropriate Medicare rebates which are expected to reduce the out-of-pocket costs to consumers associated with these procedures.</td>
<td>With new surgical techniques, the more difficult part of the surgery is now performed by the perineal surgeon. This part of the surgery requires extra training and can take more time to perform. The recommended changes to the descriptors aim to align the items and their associated fees with current surgical practices and will improve access by consumers in the private sector.</td>
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### Recommendation 7

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<th>Item</th>
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<tbody>
<tr>
<td>32046</td>
<td>Removal of part of the rectum and anus performed by two surgeons where one operates from the abdomen and one operates from the perineal end where the perineal surgeon provides assistance to the abdominal surgeon.</td>
<td>Delete the item.</td>
<td>The item would be removed from the MBS.</td>
<td>Since the development of more modern surgical procedures, this type of surgery is rarely done and is no longer considered best practice.</td>
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### Recommendation 8

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<th>Item</th>
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<tbody>
<tr>
<td>32054 and 32057</td>
<td>Removal of the large bowel, including the rectum when done by two surgical teams operating at the same time. Item 32054 can be claimed by the surgeon operating from the abdomen and item 32057 can be claimed by the surgeon operating from the perineal end.</td>
<td>That the fee for item 32054 be reduced and the fee for item 32057 be increased relative to the current fees. It is also recommended that the descriptor be amended to include use of a digital viewing platform.</td>
<td>When the patient’s large bowel is removed by two surgeons, the fee claimed by the abdominal surgeon would be reduced and the fee claimed by the perineal surgeon would be increased relative to the current fees. The procedure itself would not change, however the new items will provide more appropriate Medicare rebates which are expected to reduce the out-of-pocket costs to consumers associated with these procedures.</td>
<td>With new surgical techniques, the more difficult part of the surgery is now performed by the perineal surgeon. This part of the surgery requires extra training and can take more time to perform. The recommended changes to descriptors will improve access by consumers in the private sector.</td>
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### Recommendation 9

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<tr>
<td>32063 and 32066</td>
<td>Closure of an ileostomy (where part of the small bowel is connected to a hole in the abdominal wall) with removal of part of the rectum. The procedure also involves connection of the end of the ileum (part of the small bowel) to the anus, with or without the formation of a pouch designed to hold stool, called an ileal reservoir. These items are for surgeries with two surgeons where the abdominal surgeon claims item 32063 (which includes responsibility for the aftercare required following the operation) and the perineal surgeon claims item 32066.</td>
<td>That the fee for item 32063 be reduced and the fee for item 32066 be increased relative to the current fees. It is also recommended that the item descriptor for item 32066 be amended.</td>
<td>When this procedure is performed by two surgeons, the fee claimed by the abdominal surgeon would be reduced and the fee claimed by the perineal surgeon would be increased relative to the current fees. The descriptor for item 32066 would also be updated to better reflect the way the procedure is performed in modern practice.</td>
<td>With new surgical techniques, the more difficult part of the surgery is now performed by the perineal surgeon. This part of the surgery requires extra training and can take more time to perform. However, the ileal reservoir is typically formed by the abdominal surgeon so the fee for the item would reflect this. The recommended changes to descriptors will improve access by consumers in the private sector.</td>
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### Recommendation 10

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<tbody>
<tr>
<td>320AA and 320BB</td>
<td>Proposed new items for low or ultra-low resection of the rectum (where part of the rectum is removed and the end part of the resected bowel is attached to the anus). To claim the new items, this would need to be performed using a modern surgical technique called transanal total mesorectal excision (taTME). These two items would be claimed at the same time by two surgeons, where the abdominal surgeon will be providing patient aftercare. The abdominal surgeon will claim item 320AA and the perineal surgeon will claim item 320BB.</td>
<td>That two new items be created to reflect taTME for low or ultra-low resection of the bowel. One item would be for the abdominal surgeon and one item for the perineal surgeon. The item for the abdominal surgeon would also incorporate any required aftercare following the procedure.</td>
<td>There would be two new items on the MBS for of removal of part of the rectum using taTME when the operation is performed by two surgeons and the abdominal surgeon provides the aftercare. Creation of items for two team surgeries for low anterior resection would give patients better access to optimal care provision in private hospitals. This would be similar to what is available in major public hospitals where these complex surgeries are performed.</td>
<td>The procedure known as taTME has become increasingly performed to achieve surgical removal of the rectum in more difficult cases. The new items will better reflect the work required to perform the procedure when done by two surgeons with one surgeon operating from abdominal end and one surgeon operating from the perineal end. The fees for the new items would reflect the time, effort and training required.</td>
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<tr>
<td>320CC and 320DD</td>
<td>Proposed new items for low or ultra-low resection of the rectum (where part of the rectum is removed and the end part of the resected bowel is attached to the anus). To claim the new items, the procedure must be performed using a modern surgical technique called taTME. These items describe the same procedure as items 320AA and 320BB. However, items 320CC and 320DD are be claimed when the perineal surgeon will be providing patient aftercare. In this case, item 320DD will be claimed by the perineal surgeon and item 320CC will be claimed by the abdominal surgeon.</td>
<td>That two new items be created to reflect taTME for low or ultra-low resection of the bowel. One item would be for the abdominal surgeon and one item for the perineal surgeon. The item for the perineal surgeon would also incorporate any required aftercare following the procedure.</td>
<td>There would be two new items on the MBS for of removal of part of the rectum using taTME when the operation is performed by two surgeons and the perineal surgeon provides the aftercare. Creation of items for two team surgeries for low anterior resection would give patients better access to optimal care provision in private hospitals. This would be similar to what is available in major public hospitals where these complex surgeries are performed.</td>
<td>The procedure known as taTME has become increasingly performed to achieve surgical removal of the rectum in more difficult cases. The new items will better reflect the work required to perform the procedure when done by two surgeons with one surgeon operating from abdominal end and one surgeon operating from the perineal end. The fees for the new items would reflect the time, effort and training required.</td>
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<td>Item</td>
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<td>320EE and 320FF</td>
<td>Proposed new items for total colectomy (removal of the large bowel) with excision of the rectum and creation of an ileostomy (where the last part of the small bowel is connected to the abdominal wall to form an opening) when performing by two surgeons at the same time. To claim the new items, the procedure must be performed using a modern surgical technique called taTME. Item 320EE is to be claimed by the abdominal surgeon. Item 320FF is to be claimed by the perineal surgeon who will also provide patient aftercare.</td>
<td>That two new items be created to reflect taTME for total colectomy. One item would be for the abdominal surgeon and one item for the perineal surgeon. The item for the perineal surgeon would also incorporate any required aftercare following the procedure.</td>
<td>There would be two new items on the MBS for removal of the large bowel using taTME when the operation is performed by two surgeons and the perineal surgeon provides the aftercare.</td>
<td>The procedure known as taTME has become increasingly performed to achieve surgical removal of the rectum in more difficult cases. The new items will better reflect the work required to perform the procedure when done by two surgeons with one surgeon operating from abdominal end and one surgeon operating from the perineal end. The fees for the new items would reflect the time, effort and training required.</td>
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<tr>
<td>320GG and 320HH</td>
<td>Proposed new items for resection of the rectum, where part of the rectum is removed and the end part of the resected bowel is attached to the anus. To claim the new items, the procedure must be performed using a modern surgical technique called taTME. These procedures include the formation of an ileoanal anastomosis and ileal reservoir which is where the lower part of the small intestine is directly attached to the anal canal to allow for normal passage of stool. These two items would be claimed by two surgeons. Item 320GG will be claimed by the abdominal surgeon and item 320HH will be claimed by the perineal surgeon who will also provide patient aftercare.</td>
<td>That two new items be created to reflect taTME for rectal resection with ileoanal anastomosis and ileal reservoir. One item would be for the abdominal surgeon and one item for the perineal surgeon. The item for the perineal surgeon would also incorporate any required aftercare following the procedure.</td>
<td>There would be two new items on the MBS for removal of part of the rectum using taTME when the operation is performed by two surgeons and the perineal surgeon provides the aftercare.</td>
<td>The procedure known as taTME has become increasingly performed to achieve surgical removal of the rectum in more difficult cases. The new items will better reflect the work required to perform the procedure when done by two surgeons with one surgeon operating from abdominal end and one surgeon operating from the perineal end. The fees for the new items would reflect the time, effort and training required.</td>
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<tr>
<td>320JJ</td>
<td>Proposed new items for the removal of the anus, rectum and part of the large bowel when performed by two surgeons operating at the same time. To claim the new items, the procedure must be performed using a modern surgical technique called taTME. The abdominal surgeon would claim item 320JJ and the perineal surgeon would claim 320KK and provide patient aftercare.</td>
<td>That two new items be created to reflect taTME for abdominoperineal resection of the rectum and anus. One item would be for the abdominal surgeon and one item for the perineal surgeon. The item for the perineal surgeon would also incorporate any required aftercare following the procedure.</td>
<td>There would be two new items on the MBS for removal of the anus, rectum and part of the large bowel using taTME when the operation is performed by two surgeons and the perineal surgeon provides the aftercare.</td>
<td>The procedure known as taTME has become increasingly performed to achieve surgical removal of the rectum in more difficult cases. The new items will better reflect the work required to perform the procedure when done by two surgeons with one surgeon operating from abdominal end and one surgeon operating from the perineal end. The fees for the new items would reflect the time, effort and training required.</td>
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<tr>
<td>320KK</td>
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**Abdominoperineal resection – single surgeon**

**Recommendation 11**

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<thead>
<tr>
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<tbody>
<tr>
<td>32039</td>
<td>Removal of part of the large bowel, rectum and anal sphincter, using both abdominal and perineal incisions. Performed for the treatment for rectal cancer.</td>
<td>Leave item unchanged.</td>
<td>There would be no change to the current item.</td>
<td>The current items reflect contemporary best practice and do not need to be changed.</td>
</tr>
</tbody>
</table>
**Proctocolectomy and ileal pouches**

**Recommendation 12**

<table>
<thead>
<tr>
<th>Item</th>
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</thead>
<tbody>
<tr>
<td>32051 and 32069</td>
<td>Item 32051 is for removal of the entire large bowel with construction of a pouch from the end of the small intestine to the anus to allow for normal passage of stool. Item 32069 is for construction of the pouch alone.</td>
<td>Leave two items for proctocolectomy and ileal pouch unchanged.</td>
<td>There would be no change to the current items.</td>
<td>The current items reflect current best practice and do not need to be changed.</td>
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**Recommendation 13**

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<thead>
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<tbody>
<tr>
<td>32060</td>
<td>Removal the entire colon and rectum when the anal sphincter is left intact and a pouch, or internal reservoir, is created that allows for normal bowel function.</td>
<td>That the descriptor be amended to better describe the procedure.</td>
<td>The descriptor for the item will more accurately reflect the procedure.</td>
<td>Consumers will not be affected by the changes.</td>
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</table>

**Rectal tumours**

**Recommendation 14**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>32108</td>
<td>Surgical removal of a rectal tumour.</td>
<td>Leave item unchanged.</td>
<td>There would be no change to the current item.</td>
<td>The current item reflects contemporary practice and does not need to be changed.</td>
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</table>
## Recommendation 15

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</thead>
<tbody>
<tr>
<td>32105</td>
<td>Surgical removal of an anorectal tumour (a tumour in the anus and rectum).</td>
<td>Delete the item.</td>
<td>The item would be removed from the MBS. Consumers will not be affected by the changes.</td>
<td>There are a number of other items that could be claimed for removal of an anorectal tumour and this item is considered unnecessary.</td>
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## Recommendation 16

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<tbody>
<tr>
<td>32099</td>
<td>Surgical removal of rectal tumour. Item 32099 is for tumours 5cm in diameter or less and item 32102 is for tumours greater than 5cm in diameter.</td>
<td>Combine these two items into one item that does not specify tumour size.</td>
<td>One item would exist for rectal tumour removal instead of two separate items for tumours of different sizes. Consumers will not be affected by the changes.</td>
<td>Currently the two items are separated depending upon the size of the tumour. It is recommended the two items be combined into one item, with no reference to tumour size that should be used for the removal of smaller tumours. Larger tumours should be removed using a more appropriate procedure.</td>
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## Recommendation 17

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<tbody>
<tr>
<td>32096</td>
<td>Rectal biopsy (a procedure to remove a small piece of tissue for the rectum in order to perform laboratory testing on the sample obtained).</td>
<td>The descriptor of this item should be changed to include the diagnosis of Hirschsprung’s disease (a condition where nerve cells are missing from the large bowel) in the reasons for doing the test.</td>
<td>The item descriptor would be changed to say that this procedure is done to diagnose or exclude Hirschsprung’s disease. Consumers will not be affected by the changes.</td>
<td>This procedure is usually performed to test the tissue of the large bowel for the presence of nerve cells. The absence of nerve cells in the rectum is associated with a condition called Hirschsprung’s disease. Including this in the item descriptor would more accurately inform patients about why the test is being performed.</td>
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### Recommendation 18

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<tr>
<td>32103, 32104 and 32106</td>
<td>Removal of rectal tumours that cannot be removed during colonoscopy using digital optic viewing systems that allow the surgeon to get a better look at the area.</td>
<td>Combine items 32103 and 32104 into one item and change the descriptor for item 32106.</td>
<td>The items would be updated with current technology and the reference to tumour size in items 32103 and 32104 would be removed. Consumers will not be affected by the changes.</td>
<td>Changes to these items will not affect patients but will more accurately describe what technology is being used for removal of the tumour.</td>
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### Rectal prolapse

**Recommendation 19**

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<thead>
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<tbody>
<tr>
<td>32123 and 32131</td>
<td>Item 32123 is repair of a narrowing of the anal canal. Item 32131 is for the repair of weakened tissues of the rectum that have caused the rectum to bulge into the vagina.</td>
<td>Leave the current items unchanged.</td>
<td>There would be no change to the current items.</td>
<td>The current items reflect contemporary best practice and do not need to be changed.</td>
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**Recommendation 20**

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<tbody>
<tr>
<td>32120 and 32126</td>
<td>Item 32120 is for repair of rectal prolapse (when part of the bowel has collapsed and may protrude from out from the anus). Item 32126 describes a surgical procedure to treat accidental leakage of stool and an inability to control bowel movements.</td>
<td>These items should be deleted.</td>
<td>These items would be removed from the MBS and other items would be used for these treatments. Consumers will not be affected by the changes.</td>
<td>These items are for procedures that are no longer performed, or are more accurately described by another item.</td>
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### Recommendation 21

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<tbody>
<tr>
<td>32111 and 32112</td>
<td>Repair of rectal prolapse (when part of the bowel has collapsed and may protrude out from the anus).</td>
<td>Combine these two items into one item.</td>
<td>One item would now be used for repair of rectal prolapse.</td>
<td>There is no need for both of these items.</td>
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<td>Consumers will not be affected by the changes.</td>
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### Recommendation 22

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<tr>
<td>32114 and 32115</td>
<td>Treatments for rectal stricture (narrowing of the anal canal, which can make passage of stool difficult). Item 32114 is for surgical release and item 32115 is for dilatation of the rectum.</td>
<td>Combine these two items into one item.</td>
<td>One item would now be used for the treatment of rectal stricture by any method instead of two separate items for different methods.</td>
<td>There are a number of procedures that may be used to treat narrowing of the rectum. These two items are similar and combining them into one would simplify the MBS.</td>
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<td>Consumers will not be affected by the changes.</td>
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### Recommendation 23

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<tr>
<td>32117</td>
<td>Repair of rectal prolapse, which is when part of the bowel has collapsed and may protrude out from the anus. This item is used when the repair is performed through the abdomen.</td>
<td>Change the descriptor for this item to restrict co-claiming with certain other items.</td>
<td>Surgeons would no longer be able to claim this item at the same time as procedures to remove significant sections of the bowel.</td>
<td>Sometimes part of the bowel may be removed when a rectal prolapse is repaired through the abdomen. However it would not be appropriate to remove larger sections of the bowel at the same time as doing this procedure. Therefore, the item should include restrictions on doing these procedures at the same time.</td>
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### Recommendation 24

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<tr>
<td>32129</td>
<td>Repair of the anal sphincter which may have been damaged as a result of injury.</td>
<td>Change the descriptor for this item to make it simpler.</td>
<td>Unnecessary words would be removed from the descriptor.</td>
<td>A minor change is recommended to simplify the description for this item.</td>
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### Recommendation 25

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<tr>
<td>320LL</td>
<td>A new item to repair rectal prolapse (when part of the bowel has collapsed and may protrude out from the anus). This procedure uses a minimally invasive technique called ventral rectopexy, which takes longer to perform than traditional methods.</td>
<td>That a new item be created for the repair of rectal prolapse using the surgical technique called ventral rectopexy.</td>
<td>There would now be an item that surgeons can use specifically for this procedure.</td>
<td>Ventral rectopexy is already widely performed and is considered the preferred surgical method for the treatment of rectal prolapse. Having an item specifically for this procedure will more accurately indicate to consumers what procedure is being performed.</td>
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### Haemorrhoids, fistulae and abscesses

### Recommendation 26

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<th>Item</th>
<th>What it does</th>
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<th>What would be different</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32147, 32159, 32162, 32066, 32174 and 32175</td>
<td>Surgical treatments for haemorrhoids, anal fistulae and drainage of anal abscesses.</td>
<td>Leave six items for haemorrhoids, anal fistula and drainage of anal abscesses unchanged.</td>
<td>There would be no change to the current items.</td>
<td>The Committee agreed the current items reflect contemporary best practice and do not need to be changed.</td>
</tr>
</tbody>
</table>
### Recommendation 27

<table>
<thead>
<tr>
<th>Item</th>
<th>What it does</th>
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<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>32132, 32138, 32153 and 32168</td>
<td>Treatments for different anal conditions. Item 32132 is for the treatment of haemorrhoids using a technique called sclerotherapy which involves the injection of a solution into a haemorrhoid. Item 32138 is for the surgical removal of haemorrhoids, including anal skin tags. Item 32153 is for dilatation of the anus under general anaesthetic and item 32168 is for the review of a fistula wound (an abnormal connection between two hollow spaces).</td>
<td>Delete these items</td>
<td>These items would no longer exist on the MBS.</td>
<td>There are other items that describe these procedures and should be claimed in place of these items. There are no other clinical reasons to keep these items. Therefore, it is unnecessary to keep the items on the MBS.</td>
</tr>
</tbody>
</table>

### Recommendation 28

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>32142 and 32145</td>
<td>Removal of anal skin tags or polyps. Item 32145 is for the procedure when undertaken in an operating theatre or hospital.</td>
<td>Combine these two items into one item.</td>
<td>One item would exist for the removal of anal skin tags or polyps instead of two.</td>
<td>Currently these items are separated depending on whether the procedure is performed in an operating theatre or not. This distinction is unnecessary and the fee for this procedure should be the same regardless of where it is performed.</td>
</tr>
</tbody>
</table>
### Recommendation 29

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>32177 and 32180</td>
<td>Removal of anal warts. Item 32177 is for procedures of 45 minutes duration or less and item 32180 is for procedures lasting more than 45 minutes.</td>
<td>Combine these two items into one item.</td>
<td>One item would exist for the removal of anal warts instead of two separate item for surgeries of different durations.</td>
<td>Currently these two items are separated depending on how long the procedure takes to perform. It is not considered best practice to take a long time to remove anal warts as extensive wart removal may become uncomfortable for the patient. Therefore only one item is needed for removal of anal warts with no reference made to the length of the procedure.</td>
</tr>
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</table>

### Recommendation 30

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>32135, 32139, 32150, 32156 and 32165</td>
<td>Surgical treatments for haemorrhoids or anal fistulae. Item 32135 is for the removal of haemorrhoids using a rubber band or other techniques. Item 32139 is for the surgical removal of haemorrhoids which protrude out through the anus. Item 32150 is for the repair of an anal fissure (a break or tear in the skin of the anus). Item 32156 is for the repair of an anal fistula (an abnormal connection between two hollow spaces) and item 32165 is for the repair of an anal fistula using a technique called mucosal flap advancement.</td>
<td>Minor changes should be made to the descriptors of these items to correct outdated wording or to simplify the items.</td>
<td>The descriptors for the removal of haemorrhoids procedures would be simplified so that one item is used for non-surgical treatment and the other is used for surgical treatment. The descriptors for items for treatment of anal fistulae would be updated to reflect current practice.</td>
<td>Updating the descriptors of these items will better describe modern practice.</td>
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</tbody>
</table>
**Graciloplasty**

**Recommendation 31**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>32200, 32203, 32206 and 32209</td>
<td>A procedure where a muscle from the inner thigh is surgically wrapped around the anus. This is performed for the treatment of faecal incontinence (the inability to control bowel movements).</td>
<td>These four items should be deleted.</td>
<td>No items for this procedure would exist on the MBS.</td>
<td>This surgery is no longer considered best practice as it carries considerable risk of patient complications. There are newer procedures that should be used to treat faecal incontinence in place of these procedures.</td>
</tr>
</tbody>
</table>

**Sacral nerve lead items**

**Recommendation 32**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>32210, 32214 and 32217</td>
<td>A treatment for faecal incontinence where a stimulator is inserted into the lower back and an electrical current is used to stimulate a nerve that helps control bowel function.</td>
<td>That these three items should be combined into one item and the descriptor for the new item is amended.</td>
<td>There would be one item for placement of the stimulator. Also, the descriptor would be changed to allow access for a broader group of patients.</td>
<td>There is now more evidence for the benefits of this treatment than there was when it was originally listed on the MBS in 2005. It is appropriate that more patients will now be able to receive sacral nerve treatment and the item descriptor should be amended to reflect modern practice.</td>
</tr>
</tbody>
</table>
### Recommendation 33

<table>
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<tr>
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<tbody>
<tr>
<td>32213, 32215, 32216 and 32218</td>
<td>These procedures are for the insertion, adjustment or removal of the stimulator or leads used in sacral nerve stimulation for the treatment of faecal incontinence.</td>
<td>That the descriptors of these items are updated.</td>
<td>Previous restrictions on who is eligible for this treatment will be removed.</td>
<td>There is now more evidence for the benefits of this treatment than there was when it was originally listed on the MBS in 2005. It is appropriate that more patients will now be able to receive sacral nerve treatment and the item descriptor should be amended to reflect modern practice.</td>
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</table>

### Diagnostic item

### Recommendation 34

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>11833</td>
<td>Assesses the health of the muscles and nerves of the pelvic floor.</td>
<td>This item should remain unchanged.</td>
<td>There would be no change.</td>
<td>The Committee agreed the item reflects contemporary best practice and does not need to be changed.</td>
</tr>
</tbody>
</table>

### Ungrouped colorectal surgery items

### Recommendation 35

<table>
<thead>
<tr>
<th>Item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>32036, 32047, 32183, 32186 and 32212</td>
<td>Different colorectal procedures.</td>
<td>Leave five items for colorectal surgery unchanged.</td>
<td>There would be no change to the current items.</td>
<td>The Committee agreed the current items reflect current best practice and do not need to be changed.</td>
</tr>
</tbody>
</table>
### Recommendation 36

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>32029, 32220 and 32221</td>
<td>Item 32029 is a procedure that creates an internal pouch that allows for the storage of stool for normal bowel function. Items 32220 and 32221 are procedures to insert or remove an artificial bowel sphincter (an implant that functions like the anal muscle to manage faecal incontinence).</td>
<td>That these items are deleted.</td>
<td>These items would no longer be listed on the MBS.</td>
<td>The creation of a pouch is often performed as part of surgeries to remove the rectum. It is recommended that the item for pouch creation should be incorporated items for rectal removal. This will increase clarity for consumers. The use of artificial bowel sphincters is no longer considered best practice as there is a high rate of complications associated with the procedure. There are other procedures that are preferred in the surgical treatment of faecal incontinence.</td>
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### Recommendation 37

<table>
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<tr>
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<tr>
<td>32171</td>
<td>Internal examination of the rectum.</td>
<td>The descriptor of this item should be changed.</td>
<td>This procedure should now include an option for faecal disimpaction (the manual removal of stool that cannot otherwise be passed).</td>
<td>Faecal impaction is currently included in another item, which is now recommended for deletion. It is appropriate to include it as part of a rectal examination.</td>
</tr>
</tbody>
</table>
## Peritonectomy

### Recommendation 38

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<thead>
<tr>
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<tbody>
<tr>
<td>320MM, 320NN</td>
<td>Treatment for cancers involving the peritoneal cavity. These include pseudomyxoma peritonei, appendiceal cancer, colorectal cancer and peritoneal mesothelioma. It may also be used for some other forms of cancer. Peritonectomy is the surgical removal of the cancer and the use of chemotherapy directly to the abdomen.</td>
<td>Create two new items for peritonectomy with hyperthermic intraperitoneal chemotherapy (where chemotherapy drugs are injected directly into a tumour).</td>
<td>There would be items that can be used specifically for this surgery.</td>
<td>Currently there are no items for peritonectomy so surgeons claim a combination of other items for this procedure. The use of peritonectomy with hyperthermic intraperitoneal chemotherapy has been shown to provide excellent clinical outcomes for patients depending on type of tumour and extent of disease. Creating items for this procedure will help to improve patient access and treatment outcomes.</td>
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</table>

## Pelvic exenteration

### Recommendation 39

<table>
<thead>
<tr>
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<tr>
<td>320PP, 320QQ and 320RR</td>
<td>Exenteration surgery is performed for advanced cancers in the pelvis including colorectal and anal cancers, selected gynaecological or urological cancers, as well as recurrent pelvic cancers. This procedure involves the removal of all of the organs affected by the cancer from the pelvis.</td>
<td>The creation of three new items for exenteration surgery.</td>
<td>There would be three items that could be claimed for exenteration surgery based upon how much disease is present and how much surgery is required.</td>
<td>Currently there are no items for exenteration so surgeons claim a combination of other items for this procedure.</td>
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</table>
### Access to stomal therapy nurses

<table>
<thead>
<tr>
<th>Recommendation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>That additional consideration is given to creating items that could be claimed by stomal therapy nurses to provide care to people living with a stoma.</td>
<td>Consideration may be given to the creation of a new MBS item for stomal therapy services that could be claimed by stomal nurses. This would help improve access to these services for patients.</td>
<td>Stomal therapy nurses hold additional qualifications and can help people living with a stoma with initial and ongoing adjustment to and management of their stoma, including improved wound care.</td>
</tr>
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<td>N/A</td>
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<td>N/A</td>
<td>That additional consideration is given to creating items that could be claimed by stomal therapy nurses to provide care to people living with a stoma.</td>
<td>Consideration may be given to the creation of a new MBS item for stomal therapy services that could be claimed by stomal nurses. This would help improve access to these services for patients.</td>
<td>Stomal therapy nurses hold additional qualifications and can help people living with a stoma with initial and ongoing adjustment to and management of their stoma, including improved wound care.</td>
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32025, 32026 and 32028

Procedures involving the creation of a stoma.

That these items include an Explanatory Note to say that they should be performed in a place with enough access to stomal therapy nurses.

This would help to ensure that when a patient has a procedure that creates a stoma, that there is access to a qualified nurse to assist the patient to manage their stoma. This will improve patient equity by promoting the same level of access for all patients.

Currently there are areas around Australia where patients may not be able to access to a stomal therapy nurse. Not being able to see a stomal therapy nurse can cause stress to patients. Including an Explanatory Note for some surgical items will help to ensure that consideration is given to patient access to stomal therapy services.
<table>
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</table>
| N/A  | That the Australian Government considers what other changes could be made to help improve access to stomal therapy nurses. | It is recommended that more consideration be given to this issue. Greater access to stomal therapy nurses will assist in improving health outcomes, enabling return to work and resumption of lifestyle for people living with a stoma. It will also provide benefit through the reduction of personal and social costs associated with treatment for bowel conditions. | Stomal therapy nurses provide specialist care to people living with a stoma. The Committee recommends that consideration be given to creating MBS items for use by stomal therapy nurses but also recommends that broader consideration be given to how the MBS can reflect the work of stomal therapy nurses and improve patient access to these services. | }
Enhanced recovery after surgery

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>32000, 32003, 32004, 32005, 32009, 32012, 32015, 32018, 32021, 32024, 32025 and 32026</td>
<td>Enhanced recovery after surgery (ERAS) is a set of principles that aim to reduce the physical stress of surgery, maintain physical function and help patients to be mobile again soon after surgery.</td>
<td>That these items should include an Explanatory Note about ERAS.</td>
<td>For these surgeries, there would be an Explanatory Note on the item to say that patients should be managed by ERAS principles whenever possible.</td>
<td>ERAS principles help patients to recover more quickly which means they do not need to stay in hospital for as long, can eat and drink soon after surgery, and can return to their normal activities sooner than might otherwise be possible.</td>
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Recommendation

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<tr>
<td>N/A</td>
<td>That all other suitable surgeries should include Explanatory Notes about ERAS.</td>
<td>Colorectal, orthopaedic, urology and pancreatic surgeries would include an Explanatory Note to say that patients should be managed by ERAS principles whenever possible.</td>
<td>For these surgeries, there would be an Explanatory Note on the item to say that patients should be managed by ERAS principles whenever possible.</td>
<td>ERAS principles help patients to recover more quickly which means they do not need to stay in hospital for as long, can eat and drink soon after surgery, and can return to their normal activities sooner than might otherwise be possible.</td>
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## Consumer health literacy

### Recommendation

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<tr>
<td>N/A</td>
<td>Supports a recommendation to improve the ability of consumers to make decisions about their health by improving health education.</td>
<td>Supports a recommendation from another clinical committee of the MBS Review regarding consumer health literacy.</td>
<td>Patient education, through discussion of treatment options and written materials, would be included for a number of MBS items.</td>
<td>It is important that consumers are well supported to make educated decisions about their health. Educational materials can help patient understanding and ensure that information is remembered correctly. Treatment options should always be discussed to allow patients to give informed consent before undergoing any procedure.</td>
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### Recommendation

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<tr>
<td>N/A</td>
<td>Endorses clinical practice in line with the Royal College of Surgeons.</td>
<td>Endorses that best practice is in line with the Royal College of Surgeons’ position on informed patient consent.</td>
<td>Helps to ensure that surgeons always follow best practice in regards to informed consent.</td>
<td>Surgeons should discuss the nature of the patient’s illness or disease, the diagnosis, proposed treatment and any other options for treatment. This helps consumers understand the risks and outcomes for any procedure and to make their own informed decisions.</td>
</tr>
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<tr>
<td>N/A</td>
<td>Looks to increase consumer education before undergoing colorectal surgery.</td>
<td>Encourages the use of education materials available from the Colorectal Surgical Society of Australia and New Zealand on many colorectal procedures.</td>
<td>Helps increase patient understanding prior to undergoing surgery.</td>
<td>It is important that consumers are well supported to make educated decisions about their health. Educational materials can help patient understanding and ensure that information is remembered correctly. Treatment options should always be discussed to allow patients to give informed consent before undergoing any procedure.</td>
</tr>
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