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Neuromodulation Society of Australia and New Zealand
A chapter of the International Neuromodulation Society ins

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The Honourable Greg Hunt MP
Minister for Health
Minister Assisting the Prime Minister for the Public Service and Cabinet House of Representatives
Parliament House
PO Box 6022
Canberra ACT 2600

By email: Greg.Hunt.MP@aph.gov.au

28th February 2022

Dear Minister,

**Re: The 1 March 2022 changes to Pain Management Services on the Medicare Benefits Schedule (MBS).**

The Neuromodulation Society of Australia and New Zealand (NSANZ) is a not-for-profit medical society [1] aimed at, raising knowledge and awareness of neuromodulation, and promoting its safe practice and research in this field of medicine.

We have significant concerns in relation to the implementations of the MBS Review Task Force Report on the Review of Pain Management Item numbers of 2019 (MBS) [2]. We have serious concerns about how this will impact the 3,200,000 Australians that suffer with chronic pain [3].

We are committed to ensuring the most cost-effective delivery of medical care in the field of pain medicine and keen to work with the government and primary stakeholders.

We are calling for the following to be done immediately:
- The role out of these changes needs to be halted.
- The inconsistencies require careful and urgent re-consideration and correction.
- The many unanswered questions need clear answers and explanations.
- The MBS Task Force Committee will need to be re-convened to understand why their recommendations were not implemented.
- Corrections, explanations need to be made.
- Answers to our questions need to be addressed.

## Cost of chronic pain

Just a reminder, of the Deloitte Cost of Pain Report [3], which shows:
- 3.24 million Australians are currently living with chronic pain. 54% are women and 68% of working age.
- The total financial cost of chronic pain in Australia in 2018 was $73.2 billion, comprising $12.2 billion in health system costs, $48.3 billion in productivity losses, and $12.7 billion in other financial costs, (informal care, aids and modifications and deadweight losses).
- Chronic pain causes suffering and substantial loss of quality of life, valued at an additional $66.1 billion.
- The direct and indirect costs of chronic pain are predicted to increase from $139.3 billion in 2018 to $215.6 billion by 2050.
- Chronic pain is our nation's third most costly health problem. Persistent pain leads to poor productivity at work, which frequently leads to unemployment and impoverishment, all of which are difficult to quantify.

This shows the long-term cost of chronic pain to be massive with additional unmeasured costs on productivity and quality of life.

We must do everything we can to support and treat these patients.

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Note that currently Australia is within the top ten healthcare systems worldwide [4] and costs 9.6% of GDP vs USA at 17.2% of GDP.

## The National Pain Strategy

The National Pain Strategy [5] showed chronic pain affects 20% of Australians, with this condition not being recognised as a public health issue, which it most definitely is.

Up to 80% of these people in pain are not receiving the therapy they require with waiting times of over one year to see a specialist in the public system.

## Australian Government's National Strategic Action Plan for Pain Management

A reminder that the Australian Government published *The National Strategic Action Plan for Pain Management* in May 2021, where the aim as to document an *action plan aim to improve the quality of life for people living with chronic pain in Australia* [6].

Everything about the MBS pain management appears at odds with this recent Australian Government publication and recommendations.

## MBS Pain Management Service Changes

We support ongoing healthcare reforms including MBS updates and efficiencies, but we must maintain our world-class clinical care.

Radiofrequency neurotomy can help patients to control and wean opioids [7] and improve function [8]. This therapy significantly reduces healthcare utilisation [9].

We have significant concerns with what appears to be multiple issues with the understanding and implementation of the MBS Pain Management Item Numbers Review as well as many omissions.

The Commonwealth-appointed Pain Management Clinical Committee made recommendations to the MBS Taskforce for changes to pain management item numbers which were supported by stakeholders.

However, what has become clear in the last few weeks is that the implementation-of these recommendations is markedly different from those intended by the MBS appointed medical committee.

## With regards to radiofrequency neurotomy

Therapies such a radiofrequency neurotomy are minimally invasive therapy used for the treatment of osteoarthritic spinal facet joint pain, which is one of the commonest causes of chronic back pain across the globe. It is a safe and effective alternative to medications such as opioids and repeated facet joint injections. It reduces healthcare utilisation.

It appears that currently the legislation is as follows and aimed at 'complete medical service'.

- One episode of care for one region of the spine = one joint = one item number & can have 3 episodes of care per year.
    - You can use the 3 allocated item numbers over the year.
    - This implies you can only treat a single joint in a region of the spine up to 3 times a year.

- The spine has been divided into 6 regions (left and right, cervical, thoracic and lumbar)
    - The item numbers describe treatment of *a* single zygapohyseal joint but for your information
    - There are 6 cervical facet joints, 11 thoracic facet joints, 5 lumbar facet joints all of which can cause pain.
- The DoH has not implemented the Taskforces recommendations. There are multiple omissions and inconsistencies.
- When we treat each facet joint, we use a different needle and equipment, and it is a separate and additional treatment.
- There are multiple joints in a region of the spine that could be pain generators and require treatment at the same time to limit post-procedure pain, repeated treatments, repeat anaesthetics and their risks.
- The unintended consequences of not treating spinal osteoarthritic pain effectively will be the following
    - Healthcare utilisation will increase significantly.
    - Ongoing opioid use and/or escalation.
    - Repeated facet joint injections, which last for about 4-6 weeks.
        - This would cause a massive cost blowout to the budget. This would pose further and repeated risks of having multiple injections rather than a single course of radiofrequency treatment.

## No improved access to specialist and multidisciplinary care

There has been no implementation of improved access to multidisciplinary pain management, or pain management plans despite the clinical committees' recommendations and rationale.

There has been no implementation of improved access to group therapy despite the clinical committees' recommendations and rationale.

There has been no implementation of appropriate pain physician consultation item numbers despite the clinical committees' recommendations and rationale.

## The rapid consultation process

The final consultation process occurred over a matter of days in December 2021 when the country was grappling with the Omicron variant. The short consultation process appears to be aimed at getting the changes legislated and implemented on time. This is despite the committee report being published in 2019 and you have had over two years to get this safely sorted.

# Questions that we as pain specialist physicians have no answers to

- With the implementation merely days away, there are no published explanatory notes of the changes with which to guide physicians and patients of the implementations.
- With the implementation days away, we are unable to run test billing to iron out any issues. These systems have not yet been set up.
- With thousands of patients waiting for these procedures, further delays and uncertainty will significantly affect their long-term outcomes.
- Why are there limitations and restrictions to the use of a radiofrequency to a single joint in a spinal region up to three times a year when there are clearly more than one spinal joint that usually need to be treated at a time?
- When does the radiofrequency 12-month period start? Is it a calendar year? Or from the first treatment? How will you monitor this?

- What about people that have had a recent radiofrequency neurotomy e.g., in January 2022? Are they excluded from this? How will this be implemented?
- What item numbers do we use for sacro-iliac joint radiofrequency?
- Health funds are misinterpreting these suggestions even further. Patients have not been informed by the health funds that they will now not be supported for therapies they have been receiving for years to keep them stable and functional.
- Some colleagues are being told that the use of neuromodulation procedures is restricted to one lead when the clinical standard is to use a minimum of two leads [10].
- Why is there no access to improved specialist and multidisciplinary care?

These recommendations have been in place for 2 years, since 2019. Now to rush the consultation process at the very last minute has meant that there have been significant errors in the implementation and legislation of these recommendation which will ultimately impact our patients and the wider community.

## Unintended effects of the above

From the above evidence, patients are suffering already. With the implementation of these changes, their suffering will be even greater.

Patients that have been treated with procedures such as radiofrequency neurotomy of osteoarthritic spinal facet joints for years which has kept them off opioids and in work, will overnight loose access to this life saving therapy.

Patients will be pushed back into the already dysfunctional and underfunded public hospital system. This will further increase the waiting lists by thousands.

Patients that have been stable for years using these therapies, will suffer immensely. They will complain, especially when they have already postponed 2-3 times in the last 6 months because of covid hospital restrictions and lockdowns.

Patients will consider give up their private health insurance policies. Patients will return to using opioid therapy, the risks and side effects of which for our communities are clear [11].

Healthcare utilisation will increase significantly. With limited options to treat some of the pain conditions, patients will be forced to undertake repeated (every 4-6 weeks) day admissions for facet joint blocks with only provide temporary pain control until they are eligible for their next therapy. This will cause a huge blow out to hospital costs and resource utilisation.

It is disappointing that there have been significant omissions and changes despite clear recommendations.

We understand the need to reform and improve our systems, but this must *not* be at the expense of patients becoming unable to take advantage of a defined therapy that is indicated for their medical condition(s).

## We are committed to supporting the cost-effective delivery of medical care

We are committed to ensuring the most cost-effective delivery of medical care in the field of pain medicine and keen to work with the government and primary stakeholders.

It is paramount that Australian patients who are taxpayers and fund these systems are allowed continued access to medical care and can receive the most appropriate and advanced medical devices for their conditions.

Any reform of MBS changes must consider the Australian 'consumer' of these medical services, front and foremost. The consumer has chosen to pay their PHI to have quicker access to care, choose their medical specialist and be more in control of their healthcare, which reduces the burden on the public health system.

Pain management therapies must be continued to be supported for the reasons above.

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On behalf of the NSANZ membership

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## Copies

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- Pain Australia
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