RACGP
Royal Australian College *of* General Practitioners

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22 March 2019

Professor Bruce Robinson
Chair, MBS Review Taskforce

E: mbsreviews@health.gov.au

Dear Professor Robinson,

Re: Draft report from the Vascular Clinical Committee

The Royal Australian College of General Practitioners (RACGP) thanks the Vascular Clinical Committee of the Medicare Benefits Schedule (MBS) Review for the opportunity to provide feedback on the committee's draft report.

The RACGP's response covers the following key recommendations from the report:

1. **Recommendation 2:** The RACGP recommends the item descriptor should describe the circumstances in which an asymptomatic patient might require carotid ultrasound.
2. **Recommendation 3:** The RACGP questions why the rebate will apply for specialist referral if this procedure is not best practice.
3. **Recommendation 4:** The RACGP welcomes the inclusion of electronic storage of wave form, rather than limiting this to paper.
4. **Recommendation 11:** The RACGP believes it would be an unreasonable barrier to insist on vascular specialist referral for patients to access rebates.
5. **Recommendation 16:** The RACGP welcomes the recognition to require a referral from a general practitioner (GP) for all varicose vein services.

1. **Recommendation 2: Prevent low-value over-servicing of carotid duplex examinations**

The term "specialist" is too broad to be an adequate restriction for the restriction on asymptomatic patients ("not for screening or examination of asymptomatic patients **except when referred by a specialist**, with a maximum of two services per 12 months"). The item descriptor should describe the circumstances in which an asymptomatic patient might require carotid ultrasound.

2. **Recommendation 3: Prevent low-value over-servicing of renal duplex examinations**

Regarding the new restriction of specialist-only referral for renal duplex for atherosclerosis, the RACGP questions why the rebate will apply for specialist referral if this procedure is not best practice. Specific patient circumstances should decide whether a patient rebate applies, not the nature of the referring doctor.

Again, the term "specialist" is too broad: general practitioners who are fellows of the relevant colleges are also specialists.

3. **Recommendation 4: Reduce the use of ankle brachial index (ABI) for screening and improve access for podiatrists and nurse practitioners**

The inclusion of electronic storage of wave form, rather than limiting this to paper, is welcomed. We do, however, question to what extent any type of wave-form recording enhances diagnosis. Patient

access would be improved – especially in residential aged-care facilities and smaller or rural and remote practices – if simpler hand-held Doppler devices could be used. These devices make audible wave form, rather than print or digital, and they are more affordable.

4. **Recommendation 11: Support minimally invasive diagnostic alternatives to digital subtraction angiography**

There are advantages in general practitioner referral for examinations such as magnetic resonance angiography and computed tomography angiography in selected patients. It would be an unreasonable barrier to insist on vascular specialist referral for patients to access rebates. Any Medical Services Advisory Committee applications made should aim to reduce barriers to patients by allowing general practitioners to refer for these examinations in eligible patients.

5. **Recommendation 16: Require a referral from a general practitioner (GP) for all varicose vein services**

The recognition that general practitioners are central to patient healthcare and the have the appropriate patient information, communication skills and patient access to manage referrals is welcome.

The RACGP thanks the Vascular Clinical Committee again for the opportunity to comment. If you have any further queries please contact Mr Stephan Groombridge, Manager, eHealth and Quality Care on (03) 8669-0544 or at stephan.groombridge@racgp.org.au

Yours sincerely

Dr Harry Nespolon
President