

## Medicare Benefits Schedule Review Taskforce

### Response to the draft Taskforce Report from the Pain Management Clinical Committee (2018)

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## Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation by the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce). This document represents a response to the draft Taskforce Report from the Pain Management Clinical Committee (2018).

The APA welcomes the Taskforce Committee's focus on ensuring a multidisciplinary approach to the treatment of chronic pain encompassing the bio-psycho-social model and treatment approach using physiotherapy, psychology and educational elements.

We are pleased to see the recommendations for new items to enable better access to multidisciplinary care for chronic pain management (section 6.1) include the required emphasis on a long-term treatment commitment through the introduction of a Chronic Pain Management Plan.

This key shift towards a long-term multidisciplinary management plan for chronic pain to support self-management strategies encompassing allied health will ensure a more effective policy response.

The five key recommendations and proposed framework, enabling a more comprehensive, integrated and multifaceted model of care for chronic pain management, will support a stronger health system and address current key barriers to optimal care delivery.

In utilising the full multidisciplinary team, the APA welcomes the introduction of initial assessment appointments and case conferencing items for select allied health professionals. This measure will ensure the optimal skill mix is leveraged to inform the Chronic Pain Management Plan.

The APA has some concerns with regard to how these measures would apply in the rural context.

For rural communities, service and provider deficits, and distance, factor strongly. Targeted strategies are required to address any access constraints so patients can receive treatment close to home.

While the proposed framework outlines many positive measures to specifically address these, there are some implementation risks that relate to the GP workforce and capacity. The key barrier, in our view, is that the policy currently relies on the accessibility of a pain specialist or an accredited GP.

The advanced skill requirement, when imposed in the context of a rural GP, given the likely absence of a specialist physician, will be difficult to implement in some rural areas. The credentialing requirement whereby the GP needs to be accredited with a 6 months academic diploma is likely to result in service delay and access constraints for rural patients.

The APA also notes the Committee's additional skill recognition criteria as applied to allied health professionals. This stipulates a credentialing requirement in chronic pain management as determined by the relevant colleges or professional bodies.

Physiotherapists already utilise a broad scope of practice to support patients with chronic pain. The treatment of patients with acute or chronic pain is undertaken using traditional physiotherapy interventions.

For existing areas of practice, it is understood that health system drivers often influence the decision to credential. This is often to address issues regarding the perceived safety and quality of service delivery or to contain expenditure.

The APA considers that the models of care proposed, and skills required for the management of chronic pain, can be obtained via professional development courses for those practitioners with minimal experience and knowledge in this area.

The APA is committed to developing physiotherapy practice to improve pain management through new models of care using evidence-based practice in a multidisciplinary environment. As recognised by the committee in the report, the APA supports the upskilling of the existing workforce through foundation level pain science and management courses, along with accreditation of titled pain physiotherapists who have demonstrated advanced skills and knowledge in this area. The Australian College of Physiotherapy is currently implementing a specialisation in pain career pathway, further recognising the value of specialists in this area.

Enabling high value care through the expansion of the pain-related items of the MBS to support multidisciplinary, patient-centred approaches to pain management will provide an effective and lasting solution to one of the nation's priority health problems. As highlighted in the recent Deloitte Access Economics report commissioned by Pain Australia<sup>1</sup>, doubling current levels of access to multidisciplinary care could reduce health system costs by \$3.7 million (net of the \$70 million in intervention costs).

The APA congratulates the Pain Management Clinical Committee on progressing this key area of health system reform and we look forward to participating in future discussions around these important developments.

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## Introduction

The Australian Physiotherapy Association (APA) is pleased to provide further advice to the Medicare Benefits Schedule (MBS) Review Taskforce Pain Management Clinical Committee Draft Taskforce Report (2018).

We believe that a high-value health system needs to be both fair and sustainable; that it needs to be grounded in both the best available evidence and in a considered willingness to invest in emerging opportunities and technologies.

The Committee, through its framework and draft recommendations, has drawn on a solid evidence base which sees some much-welcomed shifts that will work toward lifting the nation's burden of chronic pain.

In meeting one of the Taskforce's key goals of ensuring best-practice health services, the Committee's solutions have sought to ensure a solid system response by prioritising a multidisciplinary team approach to chronic pain management.

The key recommendation of ensuring allied health services are prioritised across the pain treatment continuum through new areas of coverage will result in targeted treatment and better outcomes for patients.

It is important to note that accessing rural allied and community health services remains a significant barrier for many. Therefore, in meeting the broader Taskforce goal towards affordable and universal access, the APA considers that further policy attention will be needed to prioritise a ruralised service response.

Our submission works through the Taskforce's key recommendations, outlined in section 6.1 of the draft Report, to provide further physiotherapy-led insights to support the next phase of deliberations.

## APA response

In response to the recommendations for new items, the APA supports the core premise that the MBS does not currently support multidisciplinary, patient-centred approaches to pain management.

We welcome the five recommendations providing a framework with a focus on access to pain services across the multidisciplinary team. The utilisation of a broad range of interdisciplinary methods including face-to-face, group meetings and telehealth will ensure stronger coverage and support accessibility aims.

We note that the Committee anticipates that the exact MBS mechanisms for the management of chronic pain will be considered further in the deliberations of the Allied Health Reference Group and the General Practice Primary Care Clinical Committee.

## Recommendation 26

The APA supports the Taskforce's directions against recommendation 26, *Access to multidisciplinary pain management planning* and options (a to d) as a key shift that sees chronic pain recognised as a chronic disease (item b). We particularly welcome the extension of multidisciplinary assessment and case conferencing items for each member of the treating team (item d) to enable a stronger system response.

### Policy parameters

In terms of the broader policy requirements outlined by the Committee, in supporting the recommendations, the APA addresses each directly below.

<p><i>Shared record</i></p>	<p>The APA agrees that a form of shared medical record must be utilised in facilitating shared care arrangements.</p> <p>For rural areas, it is important to note that care is delivered by a range of providers within and across different sectors. Therefore, the shared medical record provision would need to extend to a team that could comprise practitioners and specialists from within the public and private sectors.</p>
<p><i>Allied health credentialing</i></p>	<p>The APA supports the additional criteria applied to allied health professionals in credentialing in chronic pain management as determined by the relevant colleges or professional bodies. However we acknowledge there is a balance between consolidating a highly capable workforce and ensuring access to appropriately skilled physiotherapists.</p> <p>Pain management is a core component of the physiotherapist skillset. Evidence has shown that physiotherapists can utilise a broad scope of practice to guide and support people with chronic pain towards a better quality of life.<sup>2</sup></p> <p>Enabling more upskilling and training across the full multidisciplinary team is important. Providing incentivised solutions to support the acquisition of training in pain management areas of practice as identified (practitioner) is also key.</p> <p>Physiotherapists already utilise a broad scope of practice to support patients with chronic pain. The treatment of patients with acute or chronic pain is undertaken using traditional physiotherapy interventions.</p> <p>However while we recognise the importance of credentialing to ensure advanced skills in pain management, we are cognizant of creating perverse incentives that decrease access to appropriate pain management services.</p>
<p><i>Needs based approach</i></p>	<p>A built-in time and complexity tiered approach to address differing need is also welcomed. This will support a tailored response for patients with</p>

	complex needs finding the right treatment combination and utilising emerging models of care for pain management.
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### Explanatory information

The APA provides some additional comments below to the Committee's explanatory detail.

<i>Option 26a</i>	<p>The APA, while fully supportive of the expansion to a new chronic pain item, consider that the rationale offered against recommendation 26a to impose a credentialing requirement on GPs risks limiting policy reach with clear access implications for rural communities.</p> <p>The recommendation which would require a GP to undertake Advanced Specialised Training (AST) would impose a significant barrier to rural service implementation where there is considerable existing unmet need. This would provide a particular barrier to implementation given the policy stipulates that the completion of the plan and access to relevant allied health visits is reliant on the GP being credentialed.</p> <p>Studies or evidence in demonstrating the causal relationship between credentials and outcomes for pain management seem limited.</p> <p>Lifting this requirement for rural areas to enable rural GPs (MMM 4-7) who are 'nominated' in rural areas would enable them to lead a multidisciplinary Chronic Pain Management Plan. This would enable access to related item numbers in order to facilitate access for rural patients to appropriately trained and accredited allied health practitioners.</p>
<i>Option 26b</i>	<p>The APA is supportive of the Committee's recommendation that chronic pain be recognised as a chronic disease. Further, in order to formalise within the healthcare system, that its inclusion should be listed in MBS material that relates to chronic disease item numbers, is also supported.</p>
<i>Option 26c</i>	<p>The APA supports the Committee's extension of Chronic disease items 132 and 133 and chronic pain management plan to be completed by a Specialist Pain Medicine Physician. This would align the measure to the approach used for the better access to mental health items.</p> <p>The APA also supports the further alignment of the multidisciplinary Chronic Pain Management Plan to the mental health plan items (items 2700 to 2717) enabling access to allied health services including alignment in terms of the number of visits.</p>



<i>Option 26d</i>	The APA supports the Committee's recommended approach that stipulates a role for the full multidisciplinary team for assessment and input into a management plan. This approach will enable a required multidisciplinary care path for pain utilising the required skillsets for optimal outcomes.
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## Recommendation 27

The APA supports the Taskforce's directions against recommendation 27, *Access to appropriately trained allied health services (a to c)*. The focus on enabling the allied health workforce through funded visits to support those living with chronic pain is welcomed.

This recommendation provides further detail relating to how the policy might operate through a tiered need-based approach under the current chronic disease items (b).

The direct referral by a Specialist Pain Medicine Physician (c), addresses a key system constraint. The current fragmented approach sees a patient returning to their GP for referral. The suggested approach offers a more streamlined approach limiting duplication and provides a more affordable outcome for the patient.

### Policy parameters

In terms of the broader policy requirements to recommendation 27 as outlined by the Committee, the APA has addressed these areas in our response to recommendation 26.

By way of further explanation, the APA supports the requirement for allied health participants to be accredited in chronic pain management as determined by the relevant colleges or professional bodies.

### Explanatory information

The APA supports the Committee's approach towards encompassing a strong allied health service response.

<i>Option 27a</i>	The APA supports the key shift in enabling a multi-modal approach to treatment with an emphasis on non-drug techniques. A key system enabler through funded visits utilising the allied health workforce will provide an expanded service response in addressing chronic pain.
<i>Option 27b</i>	The APA welcomes the tiered model proposal against current chronic disease items to provide additional allied health visits. This shift aligns with the literature and need for a long-term multidisciplinary management plan for effective chronic pain management. This measure addresses the limitations of the current Chronic Disease Management Plan and should be replicated there.



<i>Option 27c</i>	Lifting current system constraints whereby patients need to be referred back to their GP or participating nurse practitioner to access allied health services toward a direct referral approach is welcomed.
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## Recommendation 28

The APA supports the Taskforce's directions against recommendation 28, *Access to appropriately spaced multidisciplinary review of the person and the management plan* (a and b). The inclusion of a Multidisciplinary Chronic Pain Management Plan and patient review item with case conferencing provision extending to the full treating team is an important requirement to support the objectives of the framework.

### Policy parameters

In terms of the broader policy requirements to recommendation 28 as outlined by the Committee, the APA has addressed these directly below.

<i>Accreditation</i>	The APA notes the additional criteria stipulating that all participants should be accredited in chronic pain management. We support this as it relates to the provision of high-quality care but have concerns as raised in 29a.
<i>Plan review item</i>	<p>Improving communication between health practitioners and providing access to appropriate resources is paramount. The APA considers this requirement has been comprehensively covered.</p> <p>The APA supports the Committee's assessment that the review mechanism could potentially unlock access to additional relevant allied health rebates as required. This is an important consideration to ensure a more integrated service response can be provided to progress a model of care that is organised around the health needs (and integrated with higher level care).</p>

### Explanatory information

The APA supports the Committee's approach prioritising access to allied health professionals for chronic pain management.

<i>Option 28a</i>	The inclusion of a new listing for review would address a key system barrier. The framework outlined by the Taskforce is reliant on enabling a multidisciplinary team-based approach to chronic pain management. This is currently limited due to funding barriers to facilitate the required integration and coordination across teams.
<i>Option 28b</i>	Case conferencing items, across the full multidisciplinary team, again would support best practice in delivering care for complex cases.

	<p>Flexibility is important, particularly in the rural context, in facilitating geographically separate multidisciplinary care.</p> <p>Rural service responsiveness is determined by local need and available resources and often these teams need the flexibility to develop innovative models of care and service solutions.</p> <p>Rural teams would not necessarily reside under the one location or roof and may need to be made up of a mix of public and privately employed health professionals. The use of the shared medical record will help teams develop tailored responses against need and within local service construct.</p> <p>We agree that encompassing new technologies, beyond face-to-face or teleconferencing, as outlined by the Committee, is an important area for further development.</p>
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## Recommendation 29

The APA supports the Taskforce's directions against recommendation 29, *Access to group therapy for pain management* (a to c). The key recommendation (a) to introduce a new item to support group treatment programs in allied health for patients to access on completion of their Chronic Pain Management Plan will provide further support in the interdisciplinary treatment of comorbid pain.

Intensive pain management group programs have a significant positive impact on chronic pain patients. Ensuring appropriate reach across a broad range of accredited medical or allied health practitioners including nurses, physiotherapists, exercise physiologists, psychologists, or occupational therapists, as outlined in recommendation b, is welcomed.

To support the further deliberations around this measure, it is important to outline the policy detail from our Supplementary Submission (June 2018). This detail was provided as the basis for our recommendation (13) calling for a new MBS listing for an interdisciplinary group service for pain management.

The proposed services are described in Appendix 1 – Interdisciplinary Group Service for Pain Management Program.

As a way to test and develop new models of care, our earlier recommendation to the Taskforce suggested that this measure be introduced as an interim measure (for two years). This would enable an application for long-term funding to be considered by the Medical Services Advisory Committee (MSAC).

### Explanatory information

The APA supports the Committee's approach to ensuring a more integrated service response relating to intensive pain management group programs.

<i>Option 29a</i>	The APA supports the Committee key recommendation to ensure intensive pain management group programs can be accessed post-plan. We believe that this measure would help to expand the service system to open up intensive pain group programs outside of the public hospital system. Recognising that chronic pain is a long-term issue, we support a needs-based approach encompassing tiered levels of access to group programs.
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### Recommendation 30

The APA supports the Taskforce's directions against recommendation 30, *Telehealth (a)* for the introduction of pain management specific telehealth items for multidisciplinary (medical, nursing and/or allied health professionals) assessment and review for pain management patients.

As stated in our Supplementary Submission (June 2018), telemedicine is a proven cost-effective strategy for chronic pain management. There is a broad and rapidly increasing body of evidence that demonstrates that digitally-supported physiotherapy can be effective. The evidence-base for video consultations is rapidly expanding.<sup>3</sup>

### Explanatory information

The APA supports the Committee's approach to encompassing telehealth in enabling access.

<i>Option 30a</i>	<p>Telehealth is an obvious solution and can be effectively used to deliver many services, to review patient progress, ensure effective services are delivered and provide motivation for effective management programs.</p> <p>We support the Committee's recommendation as a key measure towards addressing rural access barriers where there is a significant disease and injury burden. This measure could be utilised to address the issues raised earlier around rural GP credentialing in enabling access to the Specialist Pain Medicine Physician to enable the local multidisciplinary pain team to activate a plan.</p>
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## Service gap

### Recurrent and persistent pain: Early intervention

We believe there is a missed opportunity in this review to address the gap in service delivery that exists in the identification of people at risk developing persistent pain. There is strong evidence to support that early interventions can result in health system savings and, more importantly, reduce the negative impact of pain on quality of life for these people.

One in five Australians under the age of 65 are affected daily by chronic pain, this rises to one in three in over 65 years of age.<sup>4</sup> Chronic pain costs the Australian economy approximately \$34 billion per year, the third most costly health burden in Australia and is the leading cause of early retirement and absenteeism in the workplace.<sup>5</sup>

The Productivity Commission has recommended re-focusing of the health sector to focus on integrated and patient centered care. With some estimates saying this could save the economy \$140 billion over 20 years.<sup>6</sup>

Whilst the burden of chronic pain does not sit exclusively with musculoskeletal disorders, a significant amount of the burden does arise from these. For example, the direct costs of low back pain have been estimated at \$4.8 billion per year in Australia. In addition, the indirect costs have been estimated at over \$8 billion in Australia.<sup>7</sup>

There are well defined predictors of chronicity in the literature with respect to pain. These include high levels of pain, poor self-efficacy, poor pain-related beliefs and fear avoidance.<sup>8</sup> Early intervention to address these predictors has been shown to reduce the risk of developing chronic pain and may help address the burden of disease and prevent chronicity.<sup>9</sup>

Physiotherapy has been shown to be effective in the early intervention setting and lead to outcomes such as fewer sick days, shorter injury duration and decreased utilisation of the health care system.<sup>10</sup> Physiotherapists are well placed to employ a biopsychosocial approach to educate and promote best-practice approaches to pain including pain education and promotion of healthy movement, as well as being well placed to screen for co-morbid predictors of chronicity. Physiotherapy can help address the domains that are predictors of chronicity<sup>11</sup>.

As a result, it is important for the MBS to include services that provide early intervention physiotherapy services for people at risk of persistent pain. The presence of these services provides a routine, accessible option for patients and GPs when the risk of persistent pain is identified.

The proposed service is described in Appendix 2.

## Appendices

### Appendix 1 – Interdisciplinary Group Service for Pain Management Program

Interdisciplinary pain management program provided for a person by an eligible physiotherapist and clinical psychologist, as a GROUP SERVICE for the provision of pain education and self-management strategies if:

- (a) the person has been assessed as suitable for a pain education self-management group service under assessment item [number]; and
- (b) the service is provided to a person who is part of a group of between 6 and 10 patients inclusive; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible member of the interdisciplinary team; and or via video conference to a person in a rural or remote area
- (e) the service is of at least 90 minutes duration, consisting of input from each member of the team; and
- (f) after the last service in the group services program provided to the person under items [numbers], the eligible interdisciplinary team prepares, a written report to be provided to the referring medical practitioner outlining changes in outcome measures because of the program and a self- management plan developed in collaboration with the patient, and
- (g) an attendance record for the group is maintained by the eligible interdisciplinary team; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

to a maximum of 10 GROUP SERVICES in a calendar year. Individual revision sessions may be included under subsequent CDM plans.

## Appendix 2 - Early intervention physiotherapy services for people at risk of persistent pain.

This service will be provided to a person by an eligible physiotherapist if:

- the service is provided to a person who has pain lasting less than 6 weeks
- the person is being managed by a medical practitioner who has identified that person as showing risk factors associated with prediction of non-recovery (*high VAS, DASS or OMPQ scores*)
- the person is referred to an eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and
- the person is not an admitted patient of a hospital nor enrolled in a pain management program at a tertiary institution; and
- the service is provided to the person individually and in person or via video consultation for rural and remote patients
- The initial consultation is of at least 45 minutes duration and includes:
- Use of psychosocial screening tools – Site specific outcome measures (eg DASH), PSFS, OMPQ
- Functional measures to demonstrate progression such as patient specific functional scales
- The follow-up consultations of at least 30 minutes duration and includes:
- Pain education
- Interventions targeted at addressing the barriers to recovery identified at the initial assessment
- Active strategies that encourage self-management
- after the first five (5) services, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c) outlining the baseline measures of biopsychosocial and functional parameters and provides written demonstration of how the barriers to recovery have been addressed, as well as progressions in these measures over time
- the person has been shown to have made demonstrable progress in the report mentioned in paragraph (g) but has not yet shown complete resolution, a further 5 sessions may be recommended by the medical practitioner mentioned in paragraph (c)
- in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

These planned services are time limited being deliverable in up to ten planned sessions in a calendar year. Claims for this service may not exceed this maximal limit.

## Australian Physiotherapy Association

The APA is the peak body representing the interests of Australian physiotherapists and their patients.

It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 26,000 members who conduct more than 23 million consultations each year.

To find a physiotherapist in your area, visit [www.choose.physio](http://www.choose.physio)



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