1711- Review of the MBS items for subacromial decompression

Submission by
Australian Physiotherapy Association (APA)
January 2023

Authorised by:

Anja Nikolic
Chief Executive Officer
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.australian.physio

About Australian Physiotherapy Association (APA)

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy.

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 31,000 members who conduct more than 23 million consultations each year. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives.

Acknowledgements

The APA would like to acknowledge the contribution of the physiotherapists who provided expert clinical insight and evidence regarding the Questions for Consultation for this submission. The APA would also like to acknowledge the contribution of our national speciality subgroups whose consult was sought including our clinical physiotherapy advisors in the Advanced Practice, Musculoskeletal, Orthopaedic, Pain, and Sports and Exercise committees.

Contents

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Terms of Reference

The terms of reference introduced in the Medical Services Advisory Committee (MSAC) application no. 1711 Assessment Report, Review of MBS items for subacromial decompression, with subsequent amendments are (MSAC 2022; p.12):

1. Review clinical guidelines on the management of rotator cuff disease, taking account of the clinical characteristics of the population/s recommended for subacromial decompression (SAD) (without rotator cuff repair).
2. Review the utilisation of SAD services, informed by MBS data and other data that may provide additional insight into clinical use.
3. Review evidence on comparative safety and clinical effectiveness of SAD (without rotator cuff repair) used in the management of rotator cuff disease. The evidence review will be based on the population, intervention, comparator and outcomes (PICO) confirmation ratified by the PICO Advisory sub-committee (PASC).
4. Subject to the findings of Terms of reference 1, 2 and 3, review and evaluate the cost effectiveness of SAD (without rotator cuff repair).

1. Background

The Australian Physiotherapy Association (APA) welcomes the opportunity to provide feedback to the Evaluation Sub-committee (ESC) and MSAC regarding their Review of MBS items for subacromial decompression. Physiotherapists in Australia are vital to the provision of best practice, evidence-based diagnostics, treatment and return to wellbeing of people with shoulder pain, including those with subacromial pain and impingement signs and symptoms. The APA acknowledges that the ESC and MSAC are seeking consultation on the following Questions for Consultation:

1. In the trials and in usual practice, X-ray, US and MRI are used to exclude other shoulder pathologies or determine the state of rotator cuff tendons, rather than to identify the source of the impingement. A small number of publications use X-ray to identify radiologic causes of impingement. Is this useful in clinical practice and in patient selection?

2. Are there any other patient characteristics or selection criteria which are relevant for patient selection, or to identify patients who may best benefit from surgery?

3. At baseline, patients in the trials have unclear or varied access to previous conservative therapies including physiotherapy or exercise therapy. Publications suggest that patient experiences of conservative therapies in Australia also varied, although it is unclear if this applies to patients who have surgery. In Australia, do patients with subacromial impingement have appropriate access to best practice conservative therapy prior to being considered for surgery?

The APA welcomes the opportunity to provide feedback to the Questions for Consultation and has utilised the expertise of clinical subcommittees and shoulder specialist physiotherapists within the APA membership base to provide robust, rigorous insight. We look forward to MBS reform which optimises funding mechanisms for people with subacromial pain in line with more clinically meaningful, evidence-based and outcomes-focused care pathways. We believe that the ESC and MSAC's decisions as part of the review of MBS items for SAD could pave the way towards compatibility between MBS funding and better health outcomes for people with this highly prevalent shoulder condition in Australia.

2. Executive Summary

The revision of MBS items for SAD complements the downward trending service utilisation of this surgical procedure as well as the dissuading evidence-base regarding its outcomes. The consolidation of multiple MBS items for SAD into one item paired with appropriate patient selection criteria could have a beneficial impact on clinical care for people with subacromial pain, as long as reform also coincides with support of more efficacious care pathways. Questions for Consultation 1 and 2 will hopefully elucidate clarity regarding clinical guidelines for radiological assessment as well as patient selection for SAD procedures. However, such considerations are only a small segment of the considerations necessary to optimise healthcare for patients with subacromial or rotator cuff related, so called, 'impingement'.

SAD utilisation is only one, not always appropriate, treatment option. Attention must be given to optimising the standard of care and outcomes associated with subacromial impingement,

with promotion of best practice first-line approaches delivered by physiotherapists being vital for patient outcomes. Suggested best practice for subacromial impingement is complex and non-operative, and this must be addressed as Consultation Question 3 acknowledges, including the reality that both access and quality remain ambivalent. A key issue is that physiotherapy is recommended as first-line management for this patient population and yet is underutilised in the care pathway. The APA advocates for funding which supports access to physiotherapy management, as well as further enquiry and engagement to optimise the non-operative care pathway for patients with subacromial pain and impingement. Restriction in SAD utilisation alone may reduce costs to the health system, and may reduce unnecessary, low value SAD procedures, but it will not reduce unmet health need for this large patient population without improving utilisation of physiotherapy as first-line management, thus conforming healthcare to recommended practice.

Summary of Recommendations:

The APA Recommends that:

Recommendation 1: In clinical guidelines for subacromial impingement, subacromial pain or rotator cuff related pain, X-ray assessment should not be recommended as first-line or routine assessment to identify a source of impingement.

Recommendation 2: In clinical guidelines for subacromial impingement, subacromial pain or rotator cuff related pain, first-line assessment should be specified as a full subjective and physical examination of the presentation to elucidate more complete biopsychosocial understanding of the shoulder presentation prior to synthesis of a management plan.

Recommendation 3: In the patient population who remain eligible for SAD, the demonstration of anatomical findings consistent with a mechanical cause of impingement local to the subacromial space should be a pre-requisite prior to selection for SAD, and radiological evidence is therefore necessary for selection, including findings from X-ray assessment. However, demonstration of anatomical findings to suffice this selection criteria is not sufficient to determine selection for surgery.

Recommendation 4: In the patient population who remain eligible for SAD, patients with functional instability should be excluded.

Recommendation 5: Non-operative management for subacromial impingement must include physiotherapy management in order to be sufficient to meet recommended standards for non-operative care prior to consideration of surgical management, and guidelines for management must stipulate this.

Recommendation 6: In the patient population who remain eligible for SAD, patients with nociplastic Chronic Pain or central sensitisation contributing to their subacromial pain presentation should be excluded.

Recommendation 7: Patients with subacromial pain syndrome, rotator cuff related subacromial pain, or subacromial impingement diagnoses should be eligible for MBS funding of a Physiotherapy Management Plan to subsidise a course of physiotherapy to ensure access to best practice non-operative therapies prior to consideration of SAD.

Recommendation 8: Guidelines for recommended practice should be implemented to improve consistency and quality of the care pathway for patients with subacromial pain to optimise assessment, diagnostics and management of this highly prevalent condition. MSAC should engage with the APA to derive these guidelines for best practice management of subacromial pain.

3. Consultation Question 1

Question 1: In the trials and in usual practice, X-ray, US and MRI are used to exclude other shoulder pathologies or determine the state of rotator cuff tendons, rather than to identify the source of the impingement. A small number of publications use X-ray to identify radiologic causes of impingement. Is this useful in clinical practice and in patient selection?

Introduction

Subacromial impingement is a shoulder condition which can be contributed to by the structures within the subacromial space, such as the local bursa and the rotator cuff tendons (Creech and Silver 2022). It is the most commonly diagnosed shoulder presentation (Beard et al. 2017; Naunton et al. 2020). The so called 'impingement' of structures itself can be contributed to by local factors, such bony spurs encroaching the subacromial space, os acromiale, other acromial morphology such as a Bigliani classified Type 3 hooked acromion, calcification of the coraco-acromial ligament and reduced acromiohumeral distance (Goud et al. 2008). X-ray can be utilised to assess for these local space occupying lesions, to varying degrees of accuracy (Goud et al. 2008), and certainly, varying degrees of clinical usefulness (Beard et al. 2015; Watts et al. 2017).

Radiological Assessment Does Not Capture the Full Picture

The clinical usefulness of radiological assessment, such as X-ray, in both determining diagnosis and guiding management of subacromial impingement is limited (Diercks et al. 2014; Reese et al. 2021). Subacromial impingement must be understood beyond what can be pictured in scans of the local anatomical tissue (Diercks et al. 2014). The terminology 'radiologic causes of impingement' is itself presumptuous of specificity. The 'cause' of the shoulder presentation may not be 'impingement', and is elucidated by the coherence of the radiological findings with the rest of the subjective and physical assessment findings (Beard et al. 2015). Hence, radiological investigation is a supplement to, not a substitute for, a complete patient assessment (Watts et al. 2017).

Even the term ‘impingement’ is often a misnomer, inadequately representing the clinical reality of most subacromial pain presentations (Cuff and Littlewood 2018). Contemporary practice has progressed to more accurate and less precise terminology such as subacromial pain or rotator cuff related pain (RCRP) (Beard et al. 2015). This progress in diagnostic comprehension is important, because misrepresentation as ‘impingement’ portrays a diagnosis of a precisely localised anatomical source which then naturally inclines towards a localised anatomical assessment (such as X-ray), and resulting management (such as SAD) which will remove or amend this localised anatomical finding (Naunton et al. 2020).

Subacromial pain is a complex, multi-factor presentation which requires multiple clinical tests to gain the information necessary to formulate efficacious management (Page 2011; Diercks et al. 2014; Rees et al. 2021). Signs are well beyond what can be identified by X-ray and are contributed to by bio-mechanical influences such as gleno-humeral instability, scapulo-thoracic weakness, rotator cuff weakness, posture, and pain in over-head elevation activities (Page 2011; Diercks et al. 2014). Symptoms are further influenced by psycho-social factors including patient attitudes and beliefs, as well as the potential influence of nociplastic Chronic Pain (Kromer et al. 2014; Overbeek et al. 2021). Hence, the clinical relevance of any X-ray finding is not determined by the X-ray results per se, but by a clinical impression informed through a full patient examination which has taken into account all these factors (Watts et al. 2017).

Even in the context of a full clinical assessment, in most circumstances, X-rays are not necessary to glean the clinical insight required to determine management decisions, and they are mainly useful for differential diagnosis and exclusion of other shoulder pathology (Garving et al. 2017). They are not recommended as first-line assessment for subacromial or rotator cuff related pain (Brun 2012; Kulkarni et al. 2015). X-ray findings are poorly correlated with clinical meaningfulness in presentations of subacromial impingement (Kanatli et al. 2012; Tran et al. 2018). Radiological referral should not be a surrogate for a thorough subjective and physical examination. Unfortunately, some practitioners over-rely on radiology to assess the clinical circumstances of subacromial pain, undermining the cluster of tests necessary to fully capture the information required to elucidate aetiology (Watts et al. 2017; Naunton et al. 2020). This over-reliance can be contributed to by uncertainty and lack of practitioner confidence in completing a thorough clinical examination (Naunton et al.

2020). After all, in order to gain insight from a full clinical examination, the practitioner must have the aptitude to interpret the cluster of signs, symptoms and impairments found within the examination, and from this point strategise a management plan (Watts et al. 2017). As guidelines regarding SAD procedures are developed, guidelines for best practice assessment and diagnostics, including if and when to refer for radiology, should also be developed.

Radiological Rationalisation for Surgical Intervention is the Bare Minimum

In contemplating the clinical value of X-ray to not just exclude but identify potential contributors to impingement, MSAC's Consultation Question 1 has posed the double-barrelled question enquiring in relation to usefulness in both clinical practice and in patient selection for surgery (MSAC 2022; p.35). However, the usefulness of X-ray in clinical practice is not the same as the usefulness of X-ray in patient selection for SAD. Patient selection for SAD surgery does indeed require at least some basis that in this selected population of patients – "the tissue is the issue", and radiological evidence (such as X-ray findings) is not just necessary, but the bare logical minimum to make the case that amendment of these radiologically identified factors by surgery will improve pain and ameliorate impairment.

As discussed, a contemporary, up-to-date and accurate understanding of subacromial pain has progressed beyond the myopic understanding that the local subacromial tissue is of dominant clinical importance when managing 'impingement' (Curtis et al. 2021). However, an outlying subsection of patients may have true mechanical impingement whereby a precise local source (such as a large bony spur within the subacromial space) bodes dubious prognosis of even best-practice, high quality physiotherapy with full patient compliance. This small subsection of subacromial presentations are the only ones with basis for selection for SAD.

So called 'failure of non-operative measures' alone is not enough to indicate that SAD; coraco-acromial ligament division, acromioplasty, excision of outer clavicle and acromioclavicular joint, removal of calcium deposit or excision of bursa should be performed. SAD's premise for performance is that the subacromial pain is caused by precise impingement related to the local tissue which SAD procedures will specifically attempt to

address (Kulkarni et al. 2015). Therefore, evidence that there is change or morphology to the structures at the subacromial space which is enough to be clinically responsible for impingement must be a pre-requisite prior to selection for surgery. Radiological evidence would therefore be required. In that sense X-ray findings could be 'useful' to provide this radiological evidence as part of patient selection for SAD. This does mean that some patients will have no basis from which they could improve with SAD-surgical therapies, regardless of their response or access to non-operative management. SAD targets precise subacromial tissues which, logically, should be identified prior to referral for surgery.

Recommendation 1: In clinical guidelines for subacromial impingement, subacromial pain or rotator cuff related pain, X-ray assessment should not be recommended as first-line or routine assessment to identify a source of impingement.

Recommendation 2: In clinical guidelines for subacromial impingement, subacromial pain or rotator cuff related pain, first-line assessment should be specified as a full subjective and physical examination of the presentation to elucidate more complete biopsychosocial understanding of the shoulder presentation prior to synthesis of a management plan.

Recommendation 3: In the patient population who remain eligible for SAD, the demonstration of anatomical findings consistent with a mechanical cause of impingement local to the subacromial space should be a pre-requisite prior to selection for SAD, and radiological evidence is therefore necessary for selection, including findings from X-ray assessment. However, demonstration of anatomical findings to suffice this selection criteria is not sufficient to determine selection for surgery.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

4. Consultation Question 2

Question 2: Are there any other patient characteristics or selection criteria which are relevant for patient selection, or for identifying patients who may best benefit from surgery?

Introduction

Currently, there is indeterminate evidence and expert opinion as to which selection criteria would bode a beneficial result whereby this result is attributable to the surgery itself, as opposed to confounders such as placebo or post-operative physiotherapy rehabilitation (Beard et al. 2017). The lack of response or relief via non-operative management is not per se enough to indicate operative management. Selection criteria should ensure that thorough access to both adequate assessment and diagnostics incorporating a bio-psychosocial approach, as well as adequate non-operative management has occurred prior to being considered for a surgical care pathway. Examination should not just be consistent with impingement and exclude other common causes of shoulder pain, examination should also exclude contributors to "impingement" pain which are not amenable to surgical decompression.

Assess for Instability

Patients with a subacromial impingement diagnosis who have functional instability require stabilisation and normalisation of neuromuscular function, and such instability requires strengthening, not surgery (Page et al. 2011; Brun 2012; Karjalainen et al. 2019). For patients with functional instability of the shoulder, any procedure which increases the joint space further should be cautioned, with glenohumeral instability acknowledged as a common exclusion criteria in research trials of SAD (Karjalainen et al. 2019). However, whether this assessment and exclusion occurs prior to referral for SAD in practice is uncertain, and selection criteria for the proposed population to remain eligible for SAD procedures should stipulate assessment of shoulder stability and exclusion of patients presenting with instability. This again highlights the need to consider not just treatment of subacromial pain, but the assessment which informs treatment decisions and that practitioners who are capable of this assessment must be involved in the process.

Best Practice Non-Operative Care Must Include Physiotherapy

Recommended non-operative care prior to consideration for surgery is a course of physiotherapy (Christiansen et al. 2016; Hohmann et al. 2022; Lavoie-Gagne et al. 2022). Practitioners considering referral for SAD must ensure that patients have accessed a course of physiotherapy as part of their non-operative management. The recommended course of physiotherapy is 3 months at minimum (Christiansen et al. 2016), and non-operative management should be implemented for at least 6 months prior to consideration of eligibility for SAD (Karjalainen et al. 2019). Non-operative care which is limited to pharmaco-analgesic management or the use of corticosteroid injections alone is not enough to meet criteria of 'failure' or non-relief from nonoperative measures for 4-6 months, and sufficient nonoperative care has only been sufficed when a course of physiotherapy has been implemented.

Consider Chronic Pain

Given that the proposed guidelines for subacromial decompression surgery propose a period of no relief after 4-6 months (MSAC 2022; p.14), it must be considered that this is also the time period which could indicate a nociplastic Chronic Pain diagnosis is relevant (Joypaul et al. 2019). It is known that patient perception, patient distress and catastrophizing, expectations of management and beliefs all impact the level of impairment and outcome for those living with subacromial pain (Kromer et al. 2014; Chester et al. 2016; Overbeek et al. 2021; Grandizio et al. 2022). Considerations of the impact of Chronic Pain, should therefore be highly relevant to this population, and it is unclear whether people with persistent subacromial pain are even assessed for non-anatomical pain related mediating factors. The presence of 'ongoing untenable symptoms' (MSAC 2022; p.14) is not a fully developed eligibility criteria, and the pain itself must be put into the perspective of whether or not it is directly attributable to mechanical cause, and whether it is disproportionate to the level of mechanical cause and potentially influenced by Chronic Pain (Overbeek et al. 2021; Grandizio et al. 2022). Patients should therefore undergo a full biopsychosocial assessment, and for those with signs of catastrophizing, distress or chronic pain, caution should be taken when even considering a surgical approach to amend pain related central sensitisation.

Proposed patient population eligible for SAD

Taking into account the above considerations, as well as the Shoulder and Elbow Society of Australia's proposed patient population eligible for SAD (MSAC 2022; p.14), physicians, physiotherapists and surgeons should regard all of the following eligibility criteria:

- **A.** Assess for and exclude glenohumeral instability.
- **B.** Best practice non-operative care must have included a course of physiotherapy management with no relief to this management over at least 4-6 months.
- **C.** Chronic Pain should be assessed for and excluded.
- **D.** Demonstrate a mechanical cause for the cuff impingement via radiological evidence of abnormal subacromial morphology, impingement or abrasion.
- **E.** Exclude other common causes of shoulder pain such as adhesive capsulitis, long head of biceps tendinopathy, osteoarthritis etc.
- **F.** Findings on clinical subjective and physical examination must be consistent with mechanical subacromial impingement with a localised anatomical source.

These criteria could be useful to assist more complete consideration prior to referral for SAD, and should be part of shared decision making with a well-informed patient who has been educated regarding the indeterminate evidence for a beneficial result with SAD. Patient presentations which do not suffice all these criteria should not be in a clinical pathway considerate of SAD as the 'fall-back' upon 'failure'.

Recommendation 4: In the patient population who remain eligible for SAD, patients with functional instability should be excluded.

Recommendation 5: Non-operative management for subacromial impingement must include physiotherapy management in order to be sufficient to meet recommended standards for non-operative care prior to consideration of surgical management, and guidelines for management must stipulate this.

Recommendation 6: In the patient population who remain eligible for SAD, patients with nociplastic Chronic Pain or central sensitisation related to their subacromial pain presentation should be excluded.

5. Consultation Question 3

Question 3: At baseline, patients in the trials have unclear or varied access to previous conservative therapies including physiotherapy or exercise therapy. Publications suggest that patient experiences of conservative therapies in Australia also varied, although it is unclear if this applies to patients who have surgery. In Australia, do patents with subacromial impingement have appropriate access to best practice conservative therapy prior to being considered for surgery?

Introduction

Access to healthcare occurs when a person with a health need is enabled to obtain and utilise health services which are approachable, acceptable, available, affordable and appropriate for their health need, and which ultimately result in health outcomes and patient satisfaction (Levesque et al. 2013; Cu et al. 2021). In Australia, patients with subacromial impingement do not have appropriate access to best practice conservative therapy prior to being considered for surgery. Best practice conservative therapy for subacromial impingement is a course of physiotherapy as first-line management (Christiansen et al. 2016; Hohmann et al. 2022; Lavoie-Gagne et al. 2022). Unfortunately, multiple factors reduce access to outcomes within the non-operative care pathway. Approachability of conservative management is reduced by referral processes which sub-ordinate the best practice pathway. Acceptability of conservative management is reduced by patient beliefs and ill-literacy of non-operative options. Affordability of conservative management is reduced by lack of funding for physiotherapy within primary care. Appropriateness of conservative management is reduced by lack of clarity on what best practice conservative care involves. These factors must be addressed to enable service delivery which promotes access and delivers outcomes for people with subacromial pain and impingement in Australia.

Patients are Seldom Referred to Best Practice Care

Recommended guidelines for best practice in subacromial impingement do exist, with expert and evidence consensus that physiotherapy should be accessed in the first instance (Brun 2012; Diercks et al. 2014; Kulkarni et al. 2015; Christiansen et al. 2016; Hohmann et al. 2022; Lavoie-Gagne et al. 2022). However, patients with subacromial impingement pain are more

likely to be referred to physiotherapy only after subacromial decompression surgery (Christiansen et al. 2016). In Australia, the Royal Australian College of General Practitioners (RACGP) promotes that 'in all cases early referral to a physiotherapist is appropriate' (Brun 2012), and three-quarters of all general practitioners (GPs) affirm that they intend to refer subacromial pain to a physiotherapist upon first presentation (Naunton et al. 2020). However, in reality only 12.6% of GPs actually make this referral in practice (Naunton et al. 2020). This is within the context that in practice, GPs refer for imaging for 53% of these patients, refer for steroid injections for 19.5% of these patients, and utilise medication with 54.7% of these patients (Naunton et al. 2020). Such practice is not best practice.

The usual care for the vast majority of patients with subacromial pain is medication without referral to physiotherapy (Naunton et al. 2020), with referral to physiotherapy only more likely after surgery (Christiansen et al. 2016). This is highly concerning and subordinating of recommended guidelines for care of subacromial impingement. Modal non-operative care is currently no better than a 'wait and see' plus pharmaco-analgesic approach to healthcare which bypasses best practice by bypassing physiotherapy referral. It is important that guidelines for subacromial impingement, and selection for SAD, specify that non-operative care must include a course of physiotherapy, to re-orient non-operative care towards sufficient access to best practice. Otherwise, patients may meet the proposed SAD selection criteria 'failure of nonoperative measures over 4-6 months' (MSAC 2022; p.14) when best practice has not even been given a chance to 'fail'.

Patient Beliefs Belie Best Practice

Patient beliefs and expectations of effectiveness are a key variable which impacts outcomes in subacromial pain presentations (Kromer et al. 2014; Chester et al. 2016; Cuff and Littlewood 2017; Overbeek et al. 2021; Grandizio et al. 2022). A pre-requisite to access is that a patient chooses, engages with and interacts with the health service (Levesque et al. 2013). Patients who believe physiotherapy is unlikely to lead to recovery are less likely to engage with physiotherapy and less likely to attain outcomes from it (Cuff and Littlewood 2017). These beliefs can be influenced by the lack of previous experience with physiotherapy (Christiansen et al. 2016), as well as the way that the physician talks about physiotherapy to the patient (Chester et al. 2016), and the influence of physician beliefs on patient expectation

of physiotherapy (Chester et al. 2016). Patient expectations and beliefs are known to create a 'performance bias,' resulting in placebo of surgical care (Karjalainen et al. 2019), and a bias in access towards these operative options due to patient beliefs (Cuff and Littlewood 2017). It is vital that physicians spend the time to consult with patients to improve expectations and promote the value of non-operative care and physiotherapy (Cuff and Littlewood 2017), to address belief systems which pose a barrier to the access of best practice management and which inherently promote a surgical approach for psychological improvement.

Best Practice Care is not Financially Accessible

Access to healthcare is not simply the availability of services (Levesque et al. 2013; Cu et al. 2021). Realised access of service is contingent on the resources required for access; the ability to pay, which is directly related to affordability of healthcare (Levesque et al. 2013; Cu et al. 2021). Physiotherapy as the first-line for patients with subacromial impingement, subacromial pain, or rotator cuff related pain is not publically funded, and this is an incriminated factor influencing lack of access to physiotherapy (Naunton et al. 2020). Lack of public funding is therefore limiting compliance with recommended best practice conservative management of subacromial pain presentations.

The Chronic Disease Management Plan (CDMP) provides subsidisation of chronic diseases, but requires a 6 month minimum history, a chronic diagnosis, and only 5 sessions over 12 months (MSAC 2022; p.51). The CDMP is not fit for purpose of best practice for subacromial pain, which requires early referral to physiotherapy and at least 6 months of non-operative management. Current chronic disease plans are thus antithetic to access of best practice care for patients with subacromial pain or impingement. A Physiotherapy Management Plan specific to subacromial pain (also referred to as rotator cuff related pain), consisting of subsidisation of a course of first-line physiotherapy, would open this care pathway for patients and afford them realised access of best care. Otherwise, whilst evidence and expert consensus dissuade from first-line radiological investigation and operative intervention without physiotherapy first, funding mechanisms do the opposite, orienting patient pathways away from best practice towards these second-line options and thus eclipsing the best practice care pathway.

It is important to remember that it is not only best practice 'therapy', but also best practice assessment and diagnostics that must be accessible, as discussed in Consultation Questions 1 and 2. Physiotherapists have a core, competent role in synthesis of a management plan which takes into account a full biopsychosocial assessment. Lack of funding for physiotherapy is not only a barrier for non-operative therapy but also a barrier for best practice assessment and diagnostics, and this is likely leading to the overreliance on radiological assessment by practitioners who may not have the capacity to conduct a complete assessment. Current low value care in general practice is likely leading to even more presentations of rotator cuff related or subacromial pain in Australian general practice (Naunton et al. 2022), whereby patients are not recovering and remaining in the GP caseload along with new presentations. Subacromial or rotator cuff related pain does not have to be chronic and these patients do not have to have continuous, ongoing access which results in redundant GP presentations. But they do need access to best practice in the first instance, and funding mechanisms can facilitate this, by facilitating physiotherapy.

Guidelines for Best Practice are Unclear

Guidelines for the best practice conservative management of subacromial impingement, subacromial pain, or rotator cuff related pain are unclear, and this reduces certainty of care and increases variability in practice (MSAC 2022). Due to the complex, multi-factor aetiology of subacromial pain it is important that each patient is able to access care which best fits their presentation and needs, which means there is no 'one-size fits all' approach. However, guidelines for best practice could reduce low value, unnecessary or inadequate care, and help enable access to achieve outcomes.

The present low referrals to physiotherapy, dubious patient expectations of physiotherapy and lack of funding for physiotherapy combine to reduce access of best practice prior to surgery. Addressing these factors will promote outcomes, but, given the variability of practice in primary care, guidelines for management could further optimise care and improve clarity on what both patients and physicians could expect of best practice physiotherapy. The APA would welcome the opportunity to further consult with MSAC on how any new MBS items to promote health outcomes via a Physiotherapy Management Plan could be guided towards best practice care.

If reform does not at this stage intend to improve access to best practice physiotherapy, we want to caution; variable access to conservative options should not be the rationale for continued access to any surgical procedure which is being over-utilised in lieu of adequate care options. If improvements to best practice care as per APA recommendations, including funding of physiotherapy as first line management, are out of scope of MSACs edict, it is important that lack of access to best practice physiotherapy does not make the case for continued access to low value or unnecessary SAD procedures. It is not a 'zero-sum game' between treatment options, and patients with subacromial pain deserve better than such misconception informing funding policy. Whilst the present funding of SAD does enable health service utilisation for those diagnosed with subacromial impingement, variable access to other options is not enough to rationalise continued SAD utilisation. True access to healthcare is not just utilisation; access is only realised when service utilisation retrieves health outcomes (Levesque et al. 2013; Cu et al. 2021).

Recommendation 7: Patients with subacromial pain, rotator cuff related pain, or subacromial impingement diagnoses should be eligible for MBS funding of a Physiotherapy Management Plan to subsidise a course of physiotherapy to ensure access to best practice non-operative therapies prior to consideration of SAD.

Recommendation 8: Guidelines for recommended practice should be implemented to improve consistency and quality of the care pathway for patients with subacromial pain to optimise assessment, diagnostics and management of this highly prevalent condition. MSAC should engage with the APA to derive these guidelines for best practice management of subacromial pain.

6. Conclusion

The Australian Physiotherapy Association welcomes the opportunity to provide feedback on the Review of MBS items for subacromial decompression. The APA's recommendations related to the Questions for Consultation aim to support more accurate and more accessible care pathways for people in Australia with subacromial pain. Reform towards better health outcomes and reduced unmet need involves moving away from misconceptions whereby lack of response to non-operative treatments implies response to operative treatments. Non-operative management can be resolved via a contemporary understanding of the complexity of subacromial pain management and highlights the importance of well-trained, well-guided clinicians. The need for guidance can be addressed via optimising clinical guidelines across the entire patient pathway. The APA would welcome the opportunity to further engage with MSAC to improve clarity on best practice management which will improve the standard and quality of care for patients. However, quality non-operative management is presently inaccessible, resulting in best practice physiotherapy being a best kept secret, with financial barriers impacting access. The APA advocates for improved funding for physiotherapy as first-line management, in accordance with evidence based recommendations for care. We thank the ESC and MSAC for their consideration and the resulting reform which will hopefully see more compatibility between the evidence base, public funding of health services and improved outcomes for people with subacromial pain in Australia.

7. References

Beard D, Rees J, Rombach I, Cooper C, Cook J, Merritt N, Gray A, Gwilym S, Judge A, Savulescu J, Moser J, Donovan J, Jepson M, Wilson C, Tracey I, Wartolowska K, Dean B and Carr A (2015) 'The CSAW (Can Shoulder Arthroscopy Work?)- a placebo-controlled surgical intervention trial assessing the clinical and cost effectiveness of arthroscopic subacromial decompression for shoulder pain: study protocol for a randomise controlled trial', Trials, 16(210):1-16, doi:10.1186s13063-015-0725-y

Beard DJ, Reese JL, Rombach L, Cooper C, Merritt N, Shirkey BA, Donovan JL, Gwilym S, Savulescu J, Moser J, Gray A, Jepson M, Tracey I, Judge A, Wartoowska K and Carr AJ (2017) 'Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial', Lancet, 391:329-38

Brun S (2012) 'Shoulder injuries, Management in general practice', Australian Family Physician, 41(4):188-194, accessed 5 January 2023.

Chester R, Jerosch-Herold C, Lewis J and Shepstone L (2016) 'Psychological factors are associated with the outcome of physiotherapy for people with shoulder pain: a multicentre longditudinal cohort study', British Journal of Sports Medicine, 52:269-275.

Christiansen DH, Frost P, Frich LH, Falla D and Svendsen W (2016) 'The Use of Physiotherapy among Patients with Subacromial Impingement Syndrome: Impact of Sex, Socio-Demographic and Clinical Factors', PLoS ONE, 11(3).

Creech A and Silver S (2022) Shoulder Impingement Syndrome, StatPearls Publishing, accessed 6 January 2023. https://www.ncbi.nlm.nih.gov/books/NBK554518/

Cu A, Meister S, Lefebvre B and Ridde V (2021) 'Assessing healthcare access using the Levesque's conceptual framework- a scoping review', International Journal for Equity in Health, 20(116):1-14.

Cuff A and Littlewood C (2017), 'Subacromial impingement syndrome- What does this mean to and for the patient?' Musculoskeletal Science & Practice, 33:24-28, accessed 4 January 2023. https://www.mskscienceandpractice.com/article/S2468-7812(17)30157-1/fulltext.

Curtis DM, Bradley AT, Lin Y, Baker HP, Shi LL, Strelzow JA and Athiviraham A (2021) 'National Trends Show Declining Use of Arthroscopic Sybacrmial Decompression Without Rotator Cuff Repair', The Journal of Arthroscopic and Related Surgery, 37(12):3397-3404.

Diercks R, Bron C, Dorrestijn, Meskers C, Naber R, de Ruiter T, Willems J, Winters J and Jan van der Woude H (2014) 'Guideline for diagnosis and treatment of subacromial pain syndrome', Acta Orthopaedica, 85(3):314-322, doi:10.3109/17453674.2014.920991

Garving C, Jakob S, Bauer I, Nadjar R and Brunner UH (2017) 'Impingement Syndrome of the Shoulder', Dtsch Arztebl Int, 114(45):765-776, doi:10.3238/arztebl.2017.0765

Goud A, Segal D, Hedayati P, Pan JJ and Weissman BN (2008) 'Radiographic evaluation of the shoulder', Clinical Key, 68(1).

Grandizio LC, Choe LJ, Follett L, Laychur A and Young A (2022) 'The impact of self-efficacy on nonoperative treatment of atraumatic shoulder pain', J Osteopath Med, 122(6):297-302.

Hohmann E, Glatt V and Tetsworth K (2022) 'Subacromial Decompression in Patients With Shoulder Impingement With and Intact Rotator Cuff: An Expert Consensus Statement Using the Modified Delphi Technique Comparing North American to European Shoulder Surgeons', The Journal of Arthroscopic and Related Surgery, 38(4):1051-1065.

Joypaul S, Kelly FS and King MA (2019) 'Turning Pain into Gain: Evaluation of a Multidisciplinary Chronic Pain Management Program in Primary Care', Pain Medicine, 20(5):925-933, doi:10.1093/pm/pny241

Kanatli U, Gemalmaz HC, Ozturk BY, Voyvoda NK, Tokgoz N and Bolukbasi S (2012) 'The role of radiological subacromial distance measurements in the subacromial impingement syndrome', European Journal of Orthopaedic Surgery & Traumatology, 23:317-322. https://doi.org/10.1007/s00590-012-0960-9

Karjalainen TV, Jain NB, Page CM, Lahdeoja TA, Johnston RV, Salamh P, Ardern CL, Agarwal A, O Vandvik PO and Buchbinder R (2019) 'Subacromial decompression surgery for rotator cuff disease', Conchrane Database Syst Rev, doi: 10.1002/14651858.CD005619.pub3

Kromer T, Sieben JM, de Bie RA and Bastiaenen CHG (2014) 'Influence of fear-avoidance beliefs on disability in patients with subacromial shoulder pain in primary care: a secondary analysis', Physical Therapy, 94(12):1775-84.

Kulkarni R, Gibson J, Brownson P, Thomas M, Rangan A, Carr AJ and Rees JL (2015) 'Subacromial shoulder pain BESS/BOA Patient Care Pathways', Shoulder & Elbow, 0(0):1-9, doi:10.1177/17585732155766456

Lavoie-Gagne O, Farah G, Lu Y, Mehta N, Parvaresh KC and Forsythe B (2022), 'Physical Therapy Combined With Subacromial Cortisone Injection Is a First-Line Treatment Whereas Acromioplasty With Physical Therapy Is Best if Nonoperative Interventions Fail for the Management of Subacromial Impingement: A Systematic Review and Network Meta-Analysis', The Journal of Arthroscopic and Related Surgery, 38(8):2511-2524

Levesque JF, Harris MF and Russel G (2013) 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations', International Journal for Equity in Health, 12(18):1-9.

Medical Services Advisory Committee (MSAC) (2022), MSAC Assessment Report 1711, Review of MBS items for subacromial decompression, Commonwealth of Australia.

Naunton J, Harrison C, Britt H, Haines T and Malliaras P (2020) 'General Practice management of rotator cuff related shoulder pain: A reliance on ultrasound and injection guided care', PLoS ONE, 15(1), accessed 3 January 2-2023. https://doi.org/10.1371/journal.pone.0227688

Overbeek CL, Gademann MGJ, Kolk AK, Visser CPJ, van der Zwaal P, Nagels J and Nelissen RGHH (2021) 'Reduced psychosocial functioning in subacromial pain syndrome is associated with persistence of complaints after 4 years', Journal of Shoulder and Elbow Surgery, 30(2):223-228.

Page P (2011) 'Shoulder muscle imbalance and subacromial impingement syndrome in overhead athletes', International Journal of Sports Physical Therapy, 6(1):51-58, accessed January 7 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3105366/

Rees JL, Kulkarni R, Rangan A, Jaggi A, Bronwson P, Thomas M, Clark D, Jenkins P, Candal-Couto J, Shahane S and Peach C (2021) 'Shoulder pain diagnosis, treatment and referral guidelines for primary, community and intermediate care,' *Shoulder & Elbow,* 13(1):5-11.

Tran G, Cowling P, Smith T, Bury J, Lucas A, Barr A, Kingsbury SR and Conaghan PG (2018) 'What Imaging-Detected Pathologies Are Associated with Shoulder Symptoms and Their Persistence? A Systematic Literature Review', Arthritis Care & Research, 70(8):1169-1184. https://doi.org/10.1002/acr.23554

Watts AR, Williams B, Kim SW, Bramwell DC and Krishnan J (2017) 'Shoulder impingement syndrome: a systematic review of clinical trial participant criteria', Shoulder & Elbow, 9(1):31-41, doi:10.1177/17857326663201