24 July 2018

Ms Merrin Proctor
Chair
Allied Health Reference Group
MBS Review Taskforce

By email: mbsreview@health.gov.au

Dear Ms Proctor

Re: Allied health MBS items and audiology

Audiology Australia welcomes the opportunity to make a submission to the MBS Review Taskforce Allied Health Reference Group (Reference Group). Audiology Australia is the membership association of the profession of audiology and represents over 2,600 audiologists who practice across Australia.

Audiology Australia's submission is in two sections and builds upon our original submission made to the MBS Review Taskforce in September 2015. The first section covers Audiology Australia's general views on how the current MBS system impacts on the clinical care provided by audiologists. The second section covers Audiology Australia's specific views on MBS items 10952 and 82030 that are relevant to audiologists and currently being examined by the Reference Group. Both sections are informed by extensive feedback from Audiology Australia members.

General comments on MBS system

The MBS services provided by audiologists represent high-value patient care. We welcomed the addition of audiological services for patients with chronic conditions and complex care needs in 2004 as well as nine new Medicare items for diagnostic audiology services provided by an audiologist (Group M15-Diagnostic Audiology Services) in 2012.

However, Audiology Australia believes that the current restrictions on patient access to audiological services are reducing the potential value of these diagnostic services and other audiological services to patients.

In general, the MBS items that are available to allied health professionals including audiologists have so many conditions attached, it is very difficult to use these items effectively. These restrictions include: limits on the number, nature and length of services audiologists can provide; restrictions relating to referrals to and by audiologists, and; the requirement that audiological services must be provided in person. It also means that, in practice, audiological services under the MBS are being greatly under-utilised.

Therefore, many audiologists simply do not use them and may either charge the patient for the service and/or choose not to try to claim on Medicare. Audiologists working under the supervision of general practitioners (GPs) or Ear Nose and Throat (ENT) surgeons may claim via the Medical Director's provider number.

It also seems inconsistent that the items that relate to audiologists pay a lower rebate compared to the item numbers available to medical practitioners even though the service is undertaken by the same clinician in the same test environment and the same service is provided. The only difference is that the report is co-signed by a medical practitioner rather than by an audiologist alone.

Audiologists that work for public health providers

Audiology Australia considers that the MBS should be expanded to include audiologists that work for public health providers such as hospitals but operate audiology clinics within the hospital setting. Although these audiologists work in public health, they are often expected to see private patients and make a profit, but are not able to bill Medicare.. This is not economically viable for audiologists working within or running those practices.

Referrals to/from audiologists

Under the current MBS system, a patient must be referred to an audiologist by a medical practitioner or ENT specialist. Common examples of disruptions to the care of patients resulting from these requirements are**:**

- An adult who has their hearing assessed by an audiologist working in a hospital and who is identified as requiring hearing aids will need to obtain a referral from a medical practitioner in order to access the Department of Health's Hearing Services Program and will then require a second hearing assessment prior to being fitted with hearing aids.
- An infant who is identified as having a sensorineural hearing loss cannot be fitted with hearing aids without clearance from an ENT specialist. Long waiting times for ENT services in public hospitals can delay the hearing aid fitting with potential adverse consequences for the infant's speech and language development.

Audiologists are also currently unable to refer patients directly to an ENT specialist or other allied health practitioners (such as speech pathologists, psychologists and nurse practitioners). Examples of how this process negatively affects patients are:

- A patient identified by an audiologist as having a disorder that is most appropriately treated by surgery must return to their GP to obtain the required referral to an ENT surgeon.
- An audiologist visits a remote community and recognises that a child has otitis media with accompanying hearing loss and would benefit from use of hearing aids. The audiologist must request the local nurse to organise for the child to be seen by the next visiting medical officer so that the medical officer can make a referral to the ENT to obtain clearance to fit the hearing aids. It is often the case that there will be a six to twelve month delay before the hearing aids are actually fitted.

Audiology Australia submits that an integrated system must be developed that allows patients to seek the services of an audiologist without requirement for a medical referral and which allows audiologists to refer directly to specialists such as ENTs when necessary. These changes would streamline patient care and reduce the cost and time imposts of unnecessary appointments with other medical practitioners.

Rebates based on time/expertise

Audiology Australia also considers that there should be a move away from procedure based rebates, to focus on time spent and expertise shared. Rebates should focus on Audiological Consultation, Audiological Assessment and Long Consultation.

Specific comments on MBS items

Item 10952 – Audiology item for chronic condition and complex care needs

Although team care arrangements and multidisciplinary care plans required in MBS item 10952 appear to acknowledge the need for interdisciplinary collaboration, the current funding arrangements do not remunerate audiologists for:

- an initial assessment of the patient's needs before the care plan is developed
- case conferences for planning/review purposes
- assessment consultations with patients
- communication with GPs.

In addition, while up to five referrals can be made under MBS item 10952, they may be shared among up to 14 other allied health professions. Therefore, not only does MBS item 10952 place a limit on the total number of allied health services per calendar year, it also does not allow for longer consultations with patients which may be required in some cases. This is because adults with complex care needs assessments frequently require more time, a wider test battery, and far more in-depth case history.

Consequently, audiologists may have to set fees for longer consultations which are higher than the Medicare benefit, resulting in significant out-of-pocket costs for the patient and possibly creating disparities in the accessibility of care.

Audiology Australia strongly considers that MBS item 10952 should be reviewed to provide for the following:

- audiological consultations of different lengths, depending on the patient's needs. In particular, additional time is needed for audiologists and other allied health professionals to contribute to the planning and review of care plans for patients with a chronic condition and/or complex needs
- that decisions as to the number and nature of the services required should be based on a multi-disciplinary evaluation of the patient's needs
- an increase from the current number of five services that can be accessed by allied health professionals for chronic/complex patients to a minimum of at least 10 services.

For the profession of audiology, we submit that there is substantive evidence to support an increase in the number of appointments available to allied health professionals, including audiologists available under MBS item 10952.

Based on expert clinical consensus from Audiology Australia members, there is a minimum level of services and hours required to provide best practice hearing health care for complex/chronic patients depending on their condition. For patients with:

Tinnitus assessment and management: People being assessed for tinnitus require a thorough audiological examination (Tunkel et al., 2014). The average recommended length of a tinnitus consultation for diagnostic assessment or ongoing management averages at least one hour (Hoare et al., 2012). For persistent, bothersome tinnitus that lasts more than 6 months, it is recommended that patients undertake a form of behavioural therapy such as Tinnitus Retraining Therapy (Tunkel et al., 2014).

Vestibular assessment and management: With the treatment of vestibular (balance) assessment and management, the following is considered best practice clinical care:

- Vestibular assessment appointment hours of approximately 6 hours per year, including a comprehensive initial diagnostic assessment typically between 2-3 hours depending on the number of diagnostic tests required. Commonly required diagnostic

tests are: full audiogram, electrocochleography, Auditory Brainstem response, Caloric test, ocular Vestibular Evoked Myogenic Potential and the Video Head Impulse test. At least 1-2 review assessments may be required to monitor change in a patient's underlying function/progress after an acute episode within a year.

- Vestibular management may include a BPPV/Hallpike review session of 30 mins to monitor effectiveness of re-positioning manoeuvres and – depending on the complexity of the case – 1 to 6 reviews per year for chronic cases. There may also be a need for rehabilitation appointments, informational and adjustment counselling of approximately 1-2 hours.

Cochlear implant (CI) mapping: After CI surgery there is an intensive rehabilitation programme. Each session includes mapping (programming the CI), auditory rehabilitation (exercises to train the brain to understand sound with the CI) and learning how to manage the CI equipment. The patient is seen regularly in the first year to ensure that they have optimal access to sound and for rehabilitation.

Based on expert clinical information from an Australian CI clinic, the average number of programming appointments required for best practice clinical care of adult patients in a CI centre are as follows:

- in the first month following surgery, the patient has several sessions. The duration of each session is 1-1.5 hours (1.5 hrs for the first 2 appointments). The sessions become less frequent once the patient adapts to the sound of the CI. The average number of appointments a patient will have in the first year following CI surgery for this purpose is 10. The duration of each appointment is 1 hour.
- In the first year following surgery, patients will additionally have assessments conducted to ensure that they are performing well with the CI and achieving the goals they set pre-operatively. Speech tests are conducted with the CI on and compared to scores pre-operatively to evaluate the patient's progress. On average, there would be 3 formal assessment appointments in the first year.
- After the first year following CI surgery, patients will have (on average) two appointments per year. The duration of these appointments is 1 hour.

This is consistent with studies that recommend that adult patients should be assessed at a minimum 3, 6, 12 and 24 months after their CI implantation and thereafter at least annually (Eikelboom et al, 2014). For children, it is recommended that during the first year following CI implantation, at least eight appointments are required for activation and follow-up programming of the device (Goehring and Hughes, 2017).

Hearing assessment and re-habilitation - at least four services per calendar year would be best practice assessment of a patient. This would enable fitting of a hearing device if required, post-fitting care and device maintenance, aural rehabilitation and consultation. The best practice approach of a minimum four services per year is also consistent with current requirements of the Department of Health's Hearing Services Program.

Finally, Audiology Australia considers that MBS item 10952 should also encompass micro-suction ear wax removal if a referral by a GP is given and where water syringing is contraindicated. This would ensure people who require ear cleaning the opportunity for safe micro-suction by a trained audiologist without needing to wait months to see an ENT. It would also help avoid another commonly occurring problem, which is when a GP refers a patient to an audiologist who identifies wax, the audiologist then refers the patient to a GP for wax removal but who then sends the same patient back to an audiologist.

Item 82030 - Provision of Autism, Pervasive Developmental Disorder or Disability Services by Allied Health Professionals

MBS item 82030 is for an audiology health service provided to a child aged under 13 with autism spectrum disorder (ASD), pervasive developmental disorder and disability services. For this item, the child needs to be referred by an eligible practitioner to assist the practitioner with their diagnosis of the child or contribute to the child's treatment plan developed by the practitioner.

As recognised by the Autism Cooperative Research Centre (Autism CRC), determining auditory function is a fundamental, necessary step in diagnosing and providing interventions for ASD and related conditions. Therefore, as part of best practice, a child should have a comprehensive audiological assessment development of an ASD diagnosis. This is important because some indices for ASD may include delayed or atypical language or an adverse response to sound, which are also signs of possible hearing loss. Moreover, undiagnosed comorbid hearing impairment, if left untreated, may reduce the benefit that the child with ASD gains from the relevant early intervention therapies.

On this basis, audiologists have an important role in diagnosing (or ruling out) hearing loss in children suspected of having a diagnosis of ASD and as part of the multidisciplinary health team often involved in ASD treatment and care.

However, there are difficulties with audiologists being able to use this MBS item 82030 in practice. A referral for a hearing test is one of the first investigations that occurs when a child presents with developmental or behavioural issues. Indeed, it is considered best practice that all children being assessed for ASD have their hearing assessed to exclude hearing loss as a cause of their speech and communication delay.

However, this best practice approach reinforces the situation of the diagnosis of ASD occurring after the hearing assessment and, therefore, the referring practitioner is unlikely to reveal the true reason for the referral until all other possibilities have been excluded. This means that the audiologist is simply unable to use MBS item 80230 at that point in time.

Feedback from Audiology Australia members also indicates that the referral process and how to access rebates under MBS item 80230 is unclear. Despite specifically advertising hearing services for children with ASD, this means that some members have in fact never used this item for that reason.

In the view of Audiology Australia, the above issues highlight why the current usage numbers of MBS item 82030 by audiologists are so low. For instance, during 2016-17, there were only 533 services provided under Item 82030 with $40,522 in benefits paid. This equates to total of 2 services per 100,000 head of population.

The crucial point here is these low numbers do not reflect what is actually occurring in practice – that is, audiologists are heavily involved in the diagnosis, treatment and care of children with ASD. However, as the current structure of MBS item 82030 does not provide for audiologists' important expert role in the early stage of the diagnosis process, audiologists are simply not using it or, alternatively, using the relevant MBS item numbers available to medical practitioners if this is available to them.

Therefore, Audiology Australia strongly considers that MBS item 82030 should be revised to reflect the important roles that hearing assessment and the audiologist play in the overall diagnosis process of ASD and to enable audiologists to be able to more effectively utilise MBS item 82030.

Audiology Australia also considers that the MBS should bring the terminology of MBS item 82030 into line with the current DSM-V definitions, which changed in May 2013. ASD is now a single category that encompasses ASD, Asperger's Disorder and "Pervasive Developmental Disorder Not otherwise specified". The label of PDD-NOS is no longer a diagnostic label.

If you have any questions regarding this submission, please contact Elissa Campbell, Research and Policy Manager at Audiology Australia on (03) 9940 3094 or at elissa.campbell@audiology.asn.au.

Yours sincerely

Dr Jason Ridgway
President

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