
Medicare Benefits Schedule Review
Taskforce

Report from the Endocrinology
Clinical Committee

2017

Important note

The views and recommendations in this preliminary report from the Medicare Benefits Schedule (MBS) Review Taskforce have been released for the purpose of seeking the views of stakeholders.

This report does not constitute the final position on these items which is subject to:

△ Stakeholder feedback;

Then

△ Consideration by the MBS Review Taskforce;

Then *if endorsed*

△ Consideration by the Minister for Health; and

△ The Government.

Stakeholders should provide comment on the recommendations via the online consultation tool.

Confidentiality of comments:

If you want your feedback to remain confidential please mark it as such. It is important to be aware that confidential feedback may still be subject to access under freedom of information law.

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1. Executive Summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improves health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on each of these four key goals:

- △ Affordable and universal access.
- △ Best-practice health services.
- △ Value for the individual patient.
- △ Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce has asked the Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items that are obsolete and should be removed from the MBS.
2. Consider identified priority reviews of selected MBS services.
3. Develop a program of work to consider the balance of MBS services within its remit and items assigned to the Committee.
4. Advise the Taskforce on relevant general MBS issues identified by the Committee in the course of its deliberations.

The recommendations from the Clinical Committees are released for stakeholder consultation. The Clinical Committees will consider feedback from stakeholders and then provide recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for Health, for consideration by Government.

1.1 Areas of responsibility of the Endocrinology Clinical Committee

The Endocrinology Clinical Committee (the Committee) was established in April 2016 to make recommendations to the Taskforce regarding MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. The Taskforce asked the Committee to review endocrinology-related items.

The Committee reviewed 17 endocrinology items. An inclusive set of stakeholders is now engaged in consultation on the recommendations outlined in this report. Following this period of consultation, the recommendations will be finalised and presented to the Taskforce. The Taskforce will consider the report and stakeholder feedback before making recommendations to the Minister for Health for consideration by the Government.

1.2 Key recommendations

The Committee has highlighted its most important recommendations below. The complete recommendations (and their accompanying rationales) for all items can be found in Section 5.¹ A

¹ Recommendations that are eventually made for consideration by the Government will not necessarily reflect the final recommendations made to the Taskforce by the Committee after consultation. As stated, the Taskforce will consider these recommendations, and it may alter recommendations to bring items in line with broader changes that are being made. Additionally, the wording or structuring of item descriptors and explanatory notes may be changed to ensure consistency with the language and structure of the MBS. It should also be noted that the recommendations focus on the services provided by the items. Specific item numbers may be altered during

complete list of items, the nature of the recommendations can be found in Appendix A (in table summary form).

The Committee's recommendations for stakeholder consultation are that one item should be deleted² and its services should no longer be provided under the MBS, and 16 items should be changed³. The changes focus on encouraging best practice and simplifying the MBS to improve patient care by (i) consolidating item numbers; (ii) improving the clarity of descriptors (with support from explanatory notes); and (iii) providing clinical guidance for appropriate use through explanatory notes. The key recommendations are summarised below.

- △ **Thyroidectomy items.** Improve clinical quality by encouraging the use of total thyroidectomies and hemithyroidectomies—which have been shown to be superior to partial and subtotal thyroidectomies. This will be done by the following: (i) consolidating item 30309 under item 30296, (ii) consolidating items 30308 and 30310 into one item number for partial and subtotal thyroidectomies with a clear item descriptor, (iii) and adding explanatory notes for all thyroidectomy item numbers explaining when they should be used.
- △ **Parathyroidectomy items.** Make items clearer and easier to use in order to address inappropriate co-claiming. This involves re-wording parathyroidectomy items 30315–30320.
- △ **Synacthen stimulation test.** Address low-value testing by requiring the use of basal cortisol measurement prior to performing a Synacthen stimulation test.
- △ **Endocrine tumour removal items.** Improve clinical quality and simplify the MBS by consolidating items 30321 and 36500 (items for less extensive removal or excision of tumour or adrenal gland, respectively) under items 30323 and 30324 (extensive or complete removal of tumour or adrenal gland, respectively).
- △ **Thyroglossal cyst items.** Improve clinical quality and modernise the MBS by deleting item 30313, which is obsolete. The cyst recurrence rate for simple removal under item 30313 is three times higher than the recurrence rate for radical removal (item 30314). Patients will instead receive services under item 30314.

1.3 Consumer engagement

The Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations – and how, and why. Following the public consultation the Committee will assess the feedback from consumers and decide whether any changes are needed to the recommendations. The Committee will then send the recommendations to the Taskforce. The Taskforce will consider the recommendations as well as the information provided by consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendation to government.

The Committee's recommendations encourage agreed best practice for interventions and the most reliable and relevant testing to aid diagnosis. As consumers contribute to the work of the Committee we hope that the outcomes of the review, including clearer descriptors, are a resource which will support consumers to ask the necessary questions to participate more actively in their health care.

implementation of the eventual recommendations proposed by the Minister for Health. For example, where the Committee has requested that services for item A be consolidated under item B, the actual item number for item B may be changed in some circumstances.

² Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.

³ Describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes, (ii) the consolidation of item numbers, and (iii) splitting item numbers (e.g., splitting the current services provided across two or more items).

There is a list of all the items in plain English in Appendix C - Summary for consumers.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

What is Medicare?

Medicare is Australia's universal health scheme which enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- △ Free public hospital services for public patients;
- △ Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS); and
- △ Subsidised health professional services listed on the MBS.

What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are over 5,700 MBS items, which provide benefits to patients for a comprehensive range of services including consultations, diagnostic tests and operations.

2.2 The MBS Review Taskforce

What is the MBS Review Taskforce?

The Government established the MBS Review Taskforce (the Taskforce) as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The Review is clinician-led, and there are no targets for savings attached to the Review.

What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on each of these four key goals:

- △ **Affordable and universal access** – the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-served.
- △ **Best-practice health services** – one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base, where possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- △ **Value for the individual patient** – another core objective of the Review is to maintain an MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- △ **Value for the health system** – achieving the above elements will go a long way towards achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that

have proven benefits but are underused, particularly for patients who cannot readily access those services.

2.3 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and advise on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models. The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an on-going review of the MBS once the current Review has concluded.

As the MBS Review is to be clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in their individual capacity, rather than as representatives of any organisation.

The Taskforce asked all committees in the second tranche of the review process to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria.[1] The framework used by the committees consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value,⁴ are misused⁵ and/or pose a risk to patient safety. This step includes prioritising items as "priority 1," "priority 2" or "priority 3," using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the Committee, working groups, and relevant colleagues or colleges. (For complex cases, full appropriate use criteria were developed for the item's explanatory notes.)
5. Review provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the Review report, which provides recommendations for the Taskforce.

All MBS items were reviewed during the course of the MBS Review. However, given the breadth and timeframe for the Review, each clinical committee had to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees used a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was

⁴ The use of an intervention that evidence suggests confers no benefit or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

⁵ The use of MBS services for purposes other than those intended. This includes a range of behaviours ranging from failing to adhere to particular item descriptors or rules through to deliberate fraud.

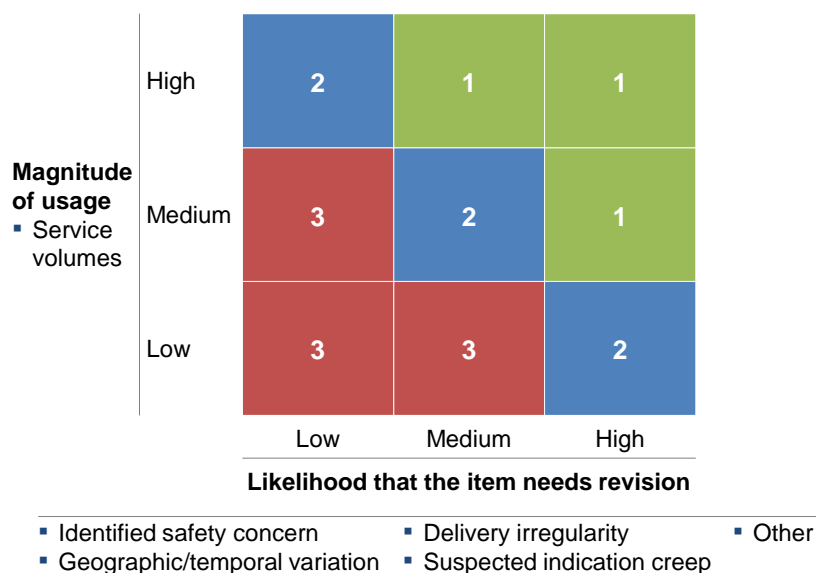
determined based on a combination of two standard metrics, derived from the appropriate use criteria:[1]

- △ Service volume.
- △ The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the Committee (such as inappropriate co-claiming).

For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Committees used this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

Figure 1: Prioritisation matrix

Prioritisation matrix



3. About the Endocrinology Clinical Committee

The Endocrinology Clinical Committee (the Committee) is part of the second tranche of clinical committees. It was established in April 2016 to make recommendations to the Taskforce on MBS items within its remit, based on rapid evidence review and clinical expertise.

The Committee consists of 13 members and three additional working group members, whose names, positions/organisations and declared conflicts of interest are listed in Sections 3.1 and 3.2. All members of the Taskforce, clinical committees and working groups were asked to declare any conflicts of interest at the start of their involvement and are reminded to update their declarations periodically.

3.1 Committee members

Table 1: Committee members

Name	Position/Organisation	Declared conflict of interest
Professor Jonathan Serpell (Chair)	Head, Breast, Endocrine & General Surgery, The Alfred; Professor & Director, General Surgery, The Alfred, Monash University; Past Chairman, Section of Endocrine Surgeons, Royal Australasian College of Surgeons; Past President, Australian and New Zealand Endocrine Surgeons	Uses the MBS items under review.
Professor Timothy Davis	Professor of Medicine, University of Western Australia; Consultant Physician and Endocrinologist, Fremantle Hospital	Uses the MBS items under review.
Professor Duncan Topliss	Director, Department of Endocrinology & Diabetes, Alfred Hospital, Melbourne; Professor of Medicine in the Department of Medicine, Monash University	Uses the MBS items under review; has given talks and previously provided advisory work for Genzyme and other pharmaceutical companies, and has contributed to their research; and has received money from thyroid cancer trials from Eisai.
Associate Professor Roderick Clifton-Bligh	Head of the Department of Endocrinology at Royal North Shore Hospital; Conjoint Associate Professor in Medicine at the University of Sydney	Uses the MBS items under review; has given talks for numerous pharmaceutical companies and contributed to their research; and has received money from thyroid cancer trials.
Professor Stan Sidhu	Professor of Surgery & Head of Endocrine Surgical Unit, University of Sydney & Royal North Shore Hospital; Professor, Surgery, Northern Clinical School, Kolling Institute of Medical Research, University of Sydney; President, Australian and New Zealand Endocrine Surgeons	Uses the MBS item numbers under review.
Dr Christopher Pyke	Surgeon, Mater Private Hospital Brisbane & Mater Private Breast Cancer Centre	Uses the MBS items under review.
Mr Peter Malycha	Director, Endocrine Surgery, Royal Adelaide Hospital; Clinical Lecturer, Department of Surgery, University of Adelaide; Consultant Surgeon, Adelaide Women's and Children's Hospital; Clinical Director, Translational Research Institute, Princess Alexandra Hospital, Centres for Health Research	Uses the MBS items under review.
Ms Helen Maxwell-Wright	Director, Maxwell-Wright Associates; Panel of Chairs, Monitoring Committee, Medicines Australia; Quality & Safety Committee, Australian and New Zealand College of Anaesthetists;	Consults for Grey Innovation/Firefly about a device under development for diabetes management.

Name	Position/Organisation	Declared conflict of interest
	Former Managing Director, International Diabetes Institute; Chair, Community Advisory Group, College of Intensive Care Medicine; Chair of State Leadership Group Victoria Juvenile Diabetes Research Foundation; MBS Review Representative Consumer	
Dr Suzanne Silberberg	Consultant Endocrinologist, private practice	Uses the MBS items under review.
Ms Janne Graham	Nominee of Consumers Health Forum; Has formerly represented consumer interests in such roles as: Member of NHMRC, Vice-Chair of Australian Pharmaceutical Advisory Council and Member of TGA Advisory Committee on Prescription Medicines; Consumer representative; healthcare advocate	Has been a patient receiving endocrine specialist services.
Dr Allan Wycherley	Head, Nuclear Medicine Unit, Division of Medical Imaging, Flinders Medical Centre	Uses the MBS items under review.
Professor Bruce Robinson	Chair of MBS Review Taskforce and Ex-Officio for the Committee; Chair of Australia's National Health, and Medical Research Council; Head of the Cancer Genetics Unit at the Kolling Institute of Medical Research, Royal North Shore Hospital; Endocrinologist, Royal North Shore Hospital	Used the item numbers and has conducted talks for Genzyme; previously on the Board for AstraZeneca and Bayer; currently on the Board for Mayne Pharma.
Dr Jo-Anne Manski-Nankervis	General Practitioner, Lecturer in Primary Care and Diabetes Research Fellow, Representative for the Department of General Practice, University of Melbourne; Primary Care Diabetes Society of Australia; Eastbrooke Medical Centres	Uses the items under review as a requesting GP.

3.2 Working group members

Table 2: Thyroid Stimulating Hormone (TSH), Thyroid Function Test (TFT) and Thyroid Antibodies Working Group members

Name	Position/Organisation	Declared conflict of interest
Associate Professor Roderick Clifton-Bligh (Chair)	As above	As above
Professor Duncan Topliss	As above	As above
Dr Suzanne Silberberg	As above	As above
Dr Jo-Anne Manski-Nankervis	As above	As above
Professor Hans Schneider	Director of Pathology, Alfred Pathology Service (Melbourne); Adjunct Clinical Professor, Central Clinical School, Monash University; President, Public Pathology Australia	Is the main biller of the tests at the Alfred, although these do not get billed under the MBS.
Dr Simon Morgan	General Practitioner	Requests the MBS items under review.

Table 3: Thyroid Surgical Volumes and Outcomes Working Group members

Name	Position/Organisation	Declared conflict of interest
Professor Jonathan Serpell (Chair)	As above	As above
Professor Stan Sidhu	As above	As above
Ms Janne Graham	As above	As above
Dr Christopher Pyke	As above	As above

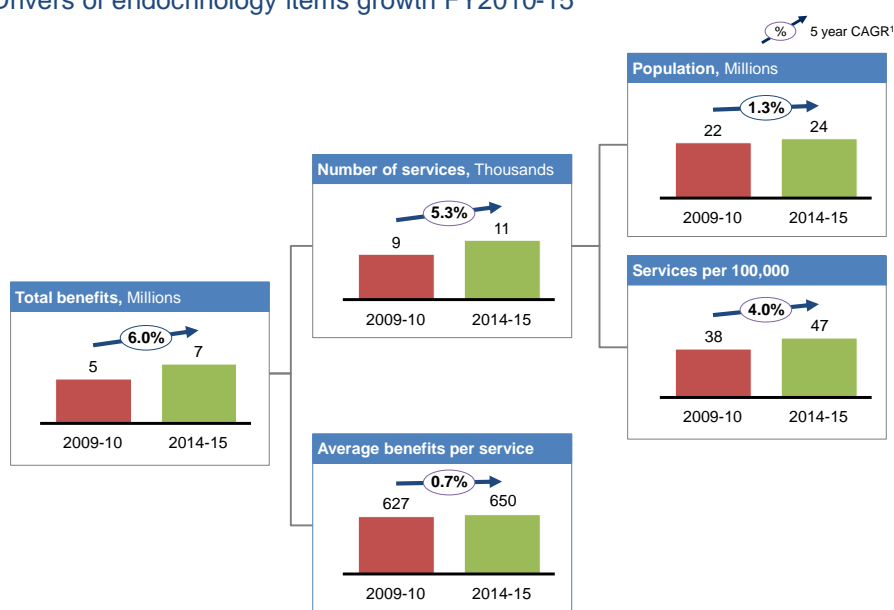
4. Areas of responsibility of the Committee

The Committee reviewed 60 MBS items: 17 endocrinology items, and 43 endocrinology-related pathology test items. The review of the 43 endocrinology-related pathology test items was performed from the perspective of doctors requesting these tests and in cooperation with the Pathology Clinical Committee (PCC; the providers), who are progressing the recommendations prior to public consultation. The Committee also provided input on 16 other items that will be referred to their primary reviewing clinical committee to assist with their recommendations for consultation.

The 17 endocrinology items primarily cover endocrinology-related surgical procedures. In FY 2014/15, these items accounted for approximately 11,000 services and \$7 million in benefits. Over the past five years, service volumes for these items have grown at 5.3 per cent per year, and the cost of benefits has increased by 6.0 per cent per year.[2] This growth is largely explained by an increase in the number of services per capita (Figure 2).[3] Thyroidectomy and parathyroidectomy services account for 83 per cent of the total services (Figure 3).

Figure 2: Endocrinology items drivers of growth

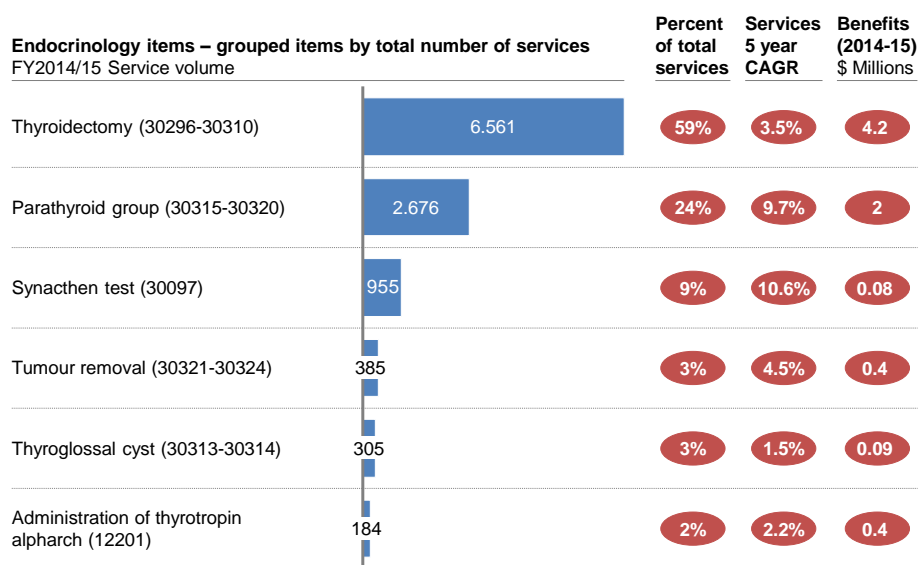
Drivers of endocrinology items growth FY2010-15



¹ Compound annual growth rate, or the average annual growth rate over a specified time period.
SOURCE: MBS data and ABS data – "3101.0 Australian Demographic Statistics Jun 2010 and Jun 2015"

Figure 3: Endocrinology item groups

Endocrinology item groups ordered by service volume



SOURCE: MBS data

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4.1 Summary of the Committee’s review approach

The Committee completed a review of its 17 allocated items across four meetings, during which it developed the recommendations and rationales outlined in Section 5. The review of the 43 endocrinology-related pathology test items was performed from the perspective of doctors requesting these tests and in cooperation with the PCC (the providers), who finalised the recommendations for consultation. Two working groups were also established to review TSH, TFT and thyroid antibodies items, as well as issues regarding the low volume of thyroid surgery performed annually by certain providers. The membership of these working groups is outlined in Section 3.2. These working groups made recommendations to the Committee, which were endorsed and included in this draft review report and in referrals to other clinical committees prior to stakeholder consultation.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional provider and patient-level data, when required. The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were sourced from relevant medical associations or colleges highlighted by Committee members, including the American Thyroid Association; medical journals, such as the *BMJ*; and other sources, such as Choosing Wisely Australia.

An inclusive set of stakeholders is now engaged in consultation on the recommendations which are outlined in this report. Following this period of consultation, the Committee will consider stakeholder feedback before finalising and presenting the recommendations to the Taskforce. The Taskforce will consider the report and stakeholder feedback before making recommendations to the Minister for Health for consideration by the Government.

5. Recommendations

The Committee reviewed 17 endocrinology items and made recommendations based on evidence and clinical expertise, in consultation with relevant stakeholders. The item-level recommendations can be found in Sections 5.1–5.6.⁶ A summary item recommendation table can be found in Appendix A. In step 1 of its review, the Committee did not identify any low-volume obsolete items. In step 2, it classified two items as priority 1, nine items as priority 2 and six items as priority 3.

The Committee’s recommendations (prior to broader stakeholder consultation) are that one item should be deleted and its services should no longer be provided under the MBS, and that 16 items should be changed. Changes focus on encouraging best practice and simplifying the MBS to improve patient care, primarily by consolidating item numbers, improving the clarity of descriptors (with the support of explanatory notes) and providing clinical guidance for appropriate use through explanatory notes.

The recommendations are presented in item groups below, with higher priority groups presented first.

5.1 Thyroidectomy: Items 30296–7, 30306 and 30308–10

Table 4: Item introduction table for items 30296-7, 30306 and 30308-10

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
30296	Thyroidectomy, total. (Anaes.) (Assist.) [1992]	\$1,023.7	2,929	\$2,124,549	4.2%
30297	Thyroidectomy following previous thyroid surgery. (Anaes.) (Assist.) [1992]	\$1,023.7	593	\$431,022	2.8%
30306	Total hemithyroidectomy. (Anaes.) (Assist.) [1992]	\$798.65	2,741	\$1,548,317	2.5%
30308	Bilateral subtotal thyroidectomy. (Anaes.) (Assist.) [1992]	\$798.65	32	\$13,343	-5.3%
30309	Thyroidectomy, subtotal for thyrotoxicosis. (Anaes.) (Assist.) [1992]	\$1,023.7	68	\$46,197	11.2%
30310	Thyroid, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy. (Anaes.) (Assist.) [1991]	\$457.4	198	\$48,476	8.8%

5.1.1 Items 30296 and 30309

Recommendation 1

- △ Consolidate item 30309 under item 30296.
- △ Leave the descriptor for item 30296 unchanged.
- △ Add the following explanatory notes: “Total Thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is

⁶ Recommendations that are eventually made for consideration by the Government will not necessarily reflect the final recommendations made to the Taskforce by the Committee after consultation. As stated, the Taskforce will consider these recommendations, and it may alter recommendations to bring items in line with broader changes that are being made. Additionally, the wording or structuring of item descriptors and explanatory notes may be changed to ensure consistency with the language and structure of the MBS. It should also be noted that the recommendations focus on the services provided by the items. Specific item numbers may be altered during implementation of the eventual recommendations proposed by the Minister for Health. For example, where the Committee has requested that services for item A be consolidated under item B, the actual item number for item B may be changed in some circumstances.

required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item X [note: item to be created, see recommendations for items 30308 and 30309 below] is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy." These explanatory notes are recommended for all thyroidectomy items other than 30297, please see recommendations for items 30306, 30308 and 30310 for further rationale. (Explanatory notes are not currently provided for these items.)

Rationale

The recommendations focus on modernising and simplifying item numbers to reflect best clinical practice. They are based on the following observations.

- △ The position of the Committee is that procedures previously performed under item 30309 should be performed as a total thyroidectomy under item 30296. This view is supported by the literature which highlights that total thyroidectomy is preferable to sub-total thyroidectomy. The American Thyroid Association and American Association of Clinical Endocrinologists' Management Guidelines for thyrotoxicosis state: "If surgery is chosen as treatment for thyrotoxicosis management or Graves' disease, near-total or total thyroidectomy should be performed" (Guidelines 40 and 24).[4] Furthermore, a review by Snook, Stalberg and Sidhu (2007) states: "Total thyroidectomy for benign multinodular goitres is not only a safe procedure but is efficacious in preventing recurrent disease." [5]
- △ MBS data also indicates comparatively limited use for item 30309. For example, in FY2014/15 sub-total thyroidectomies for thyrotoxicosis under item 30309 were only performed 69 times compared to total thyroidectomies under item 30296, which were performed 2,929 times.[6]
- △ Item 30309 has the same schedule fee as item 30296, and consolidating the items should therefore have no impact on patient access.
- △ The proposed item for partial or subtotal thyroidectomy below (see recommendations for items 30308 and 30310) can be used in the uncommon circumstances when a subtotal thyroidectomy for thyrotoxicosis is required.

5.1.2 Item 30306

Recommendation 2

- △ Leave the item descriptor unchanged.
- △ Add the following explanatory notes: "Total Thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item X [note: item to be created, see recommendations for items 30308 and 30309 below] is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy." These explanatory notes are recommended for all thyroidectomy items other than 30297, please see recommendations for items 30296 and 30309, and 30308 and 30310 for further rationale. (Explanatory notes are not currently provided for this item.)

Rationale

The recommendations focus on encouraging best clinical practice and are based on the following observations.

- △ The position of the Committee is that a total hemithyroidectomy performed under Item 30306, is the most appropriate treatment in the majority of circumstances compared to a unilateral

subtotal or equivalent partial thyroidectomy performed under item 30310. This is supported by the American Thyroid Association's Management Guidelines for adult patients with thyroid nodules and differentiated thyroid cancer, which state: "When surgery is considered for patients with a solitary, cytologically indeterminate nodule, thyroid lobectomy (hemithyroidectomy) is the recommended initial surgical approach" (Recommendation 19).[7]

- △ The Committee considered deleting item 30310 and requiring services to be provided under item 30306. However, it decided that an item number is required for the uncommon circumstances when a unilateral subtotal or equivalent partial thyroidectomy is indicated as under item 30310. Therefore, to encourage use of item 30306 instead of item 30310, the Committee recommends adding the proposed explanatory notes in line with clinical guidelines.

5.1.3 Items 30308 and 30310

Recommendation 3

- △ Consolidate items 30308 and 30310 into one item for the uncommon circumstances when a partial or subtotal thyroidectomy is indicated. The proposed item descriptor is as follows: "Partial or subtotal thyroidectomy (Anaes.) (Assist.)"
- △ Add the following explanatory notes: "Total Thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item X [note: item to be created] is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy." These explanatory notes are recommended for all thyroidectomy items other than 30297. (Explanatory notes are not currently provided for these items.)

Rationale

The recommendations focus on modernising and simplifying item numbers to reflect best clinical practice. They are based on the following observations.

- △ As stated above, the position of the Committee is that total thyroidectomies (30296) and total hemithyroidectomies (30306) should be performed in the majority of circumstances; Whereas subtotal or equivalent partial thyroidectomies performed under items 30310 and 30308, are only indicated in uncommon circumstances. Again, this is supported by the literature cited above.[4], [5], [7]
- △ MBS data also indicates that Items 30308 and 30310 are rarely performed procedures. In FY2014/15, item 30310 was used only 198 times, and item 30308 was only used 32 times. To provide a point of comparison, item 30306 was used 2,741 times, and item 30296 was used 2,929 times during the same period.[6] Furthermore, the use of item 30306 has been declining steadily by 5.3 per cent per year over the last five years.[2]
- △ The Committee wishes to make it clear that partial and subtotal thyroidectomies should only be used in uncommon circumstances. They intend to do this by consolidating the items for these procedures into one item with a clear item descriptor, and highlighting when this item should be used by the aid of explanatory notes.

5.1.4 Item 30297

Recommendation 4

- △ Leave the item descriptor unchanged.

- △ Add the following explanatory notes: “This procedure is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemi thyroidectomy for thyroid cancer, item 30306 is the appropriate item.” (Explanatory notes are not currently provided for this item.)

Rationale

The recommendations focus on encouraging best clinical practice, based on the following observations.

- △ Committee members agreed that this item should not be used as a completion procedure, and that it is incorrectly claimed in some cases.
- △ It was noted that there are currently no explanatory notes for this item. The Committee felt that including explanatory notes would further promote best practice.

5.2 Parathyroid: Items 30315, 30317–8 and 30320

Table 5: Item introduction table for items 30315, 30317-8 and 30320

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
30315	Parathyroid operation for hyperparathyroidism. (Anaes.) (Assist.) [1992]	\$1,139.90	2,020	\$1,713,523	8.6%
30317	Cervical reexploration for recurrent or persistent hyperparathyroidism. (Anaes.) (Assist.) [1992]	\$1,364.90	125	\$127,685	14.3%
30318	Mediastinum, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy). (Anaes.) (Assist.) [1992]	\$907.60	524	\$169,638	13.3%
30320	Mediastinum, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy). (Anaes.) (Assist.) [1992]	\$1,364.90	7	\$5,956	11.8%

Recommendation 5

- △ Amend the descriptors for all four items to promote best practice and improve ease of use. Proposed item descriptors are provided below.
 - 30315: Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through a small cervical incision for an image localised adenoma including thymectomy, not to be claimed with itself or items 30316, 30317 or 30320. (Anaes.) (Assist.)
 - 30316 (*previously 30318*): Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperplastic glands via a cervical incision including thymectomy and cervical exploration of the mediastinum when performed. Not to be claimed with itself or items 30315, 30317 or 30320. (Anaes.) (Assist.)
 - 30317: Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroidism including thymectomy and cervical exploration of the mediastinum, not to be claimed with itself or items 30315, 30316 or 30320. (Anaes.) (Assist.)
 - 30320: Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic approach, not to be claimed with itself or items 30315, 30316 or 30317. (Anaes.) (Assist.)
- △ Change item number 30318 to 30316 to make the order of item numbers more intuitive.

- △ The Committee advises that the revised item 30316 has a similar scope of practice to item 30315 and should have the same schedule fee.

Rationale

The recommendations focus on simplifying item numbers to reflect best clinical practice. They are based on the following observations.

- △ Existing parathyroid item descriptors are unclear, do not reflect modern use of the items and allow for unintended and intended misuse. The Committee’s position is that this results in inappropriate co-claiming. For example, in FY2014/15, item 30318 was co-claimed with item 30315 on 465 occasions—90 per cent of 30318 claims. It was also co-claimed with item 30317 on 40 occasions. Items 30315 and 30320 were co-claimed on two occasions.[8]
- △ The Committee agreed that the anticipated volume split between the new items is approximately 50 per cent minimally invasive parathyroidectomy and 50 per cent open parathyroidectomy.[9], [10]

5.3 Synacthen stimulation test: Item 30097

Table 6: Item introduction table for item 30097

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented. [2006]	\$97.15	955	\$78,224	10.6%

Recommendation 6

- △ Change the item descriptor to require a basal cortisol quantitation prior to a Synacthen stimulation test. The proposed item descriptor is provided below.
- △ Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if serum cortisol at 0830-0930 hours in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or in a patient in intensive care where adrenal insufficiency is suspected.
- △ Add explanatory notes to guide best practice. (Explanatory notes are not currently provided for this item.) Proposed explanatory notes are provided below.
 - A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.
 - A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required.

Rationale

The recommendations focus on encouraging best clinical practice and are based on the following observations.

- △ In the last five years, use of this item has increased by an annual average of 10.6 per cent, resulting in a total service volume of 977 in FY2014/15.[2] The Committee agreed that this growth and the resulting service volume are higher than expected and a likely indication of over-testing and the provision of low-value care for patients. Over-testing can occur when a basal

cortisol quantitation is (i) not taken and the results would have proven a Synacthen test to be redundant, or (ii) taken and not interpreted appropriately to avoid a redundant Synacthen test.[11]–[13] The Committee felt that this problem could be addressed by adding a requirement to the item descriptor to undertake a basal cortisol quantitation, along with clear rules describing when a Synacthen test is appropriate, supported by explanatory notes.

- △ There is consensus in the relevant literature that a morning serum cortisol of <100nmol/L is an appropriate lower bound cut-off. There is less consensus regarding the upper bound, but a conservative evaluation of the most relevant literature was conducted and the Committee agreed with the recommendation of >400 nmol/L.[14]–[16]

5.4 Thyroglossal cyst: Items 30313 and 30314

Table 7: Item introduction table for items 30313 and 30314

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
30313	Thyroglossal cyst, removal of. (Anaes.) (Assist.) [1991]	\$272.95	45	\$7,628	-5.3%
30314	Thyroglossal cyst or fistula or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone. (Anaes.) (Assist.) [1992]	\$457.40	260	\$84,185	3.0%

Recommendation 7

- △ Delete⁷ item 30313, and instead use item 30314.
- △ Change the item descriptor for item 30314 to read: “Sistrunks procedure. Excision of a thyroglossal duct cyst or fistula including removal of the body of the hyoid bone. (Anaes.) (Assist.)”

Rationale

The recommendations focus on modernising the MBS by removing obsolete items that encourage sub-optimal clinical practice. They are based on the following observations.

- △ Item 30313 is obsolete as it has a higher cyst recurrence rate than item 30314. The recurrence rate after removing a cyst is 30 per cent, compared to less than 10 per cent after removing a cyst/tract and body of the hyoid bone.[17]
- △ Clinical practice is changing, reflecting a shift away from using obsolete item 30313. The service volume for item 30313 has declined by an average of 5.3 per cent per year over the last five years, and the service volume for item 30314 has increased by 3 per cent per year.[2]
- △ There are no access issues caused by the minimum age specified in item 30314 as an equivalent item number (30326) exists for patients under 10 years of age.

⁷ Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.

5.5 Tumour removal: Items 30321, 30323–4 and 36500

Table 8: Item introduction table for items 30321, 30323–4 and 36500

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
30321	Retroperitoneal neuroendocrine tumour, removal of. (Anaes.) (Assist.) [1992]	\$907.60	13	\$7,053	-9.1%
30323	Retroperitoneal neuroendocrine tumour, removal of, requiring complex and extensive dissection. (Anaes.) (Assist.) [1992]	\$1,364.90	97	\$87,826	1.5%
30324	Adrenal gland tumour, excision of. (Anaes.) (Assist.) [1992]	\$1,364.90	275	\$267,754	6.8%
36500	Adrenal gland, excision of partial or total. [1991]	\$924.70	56	\$25,530	9.2%

Recommendation 8

- △ Consolidate item 30321 under item 30323.
- △ Change the descriptor for item 30323 to read: “Excision of pheochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.)”
- △ Change the descriptor for item 30324 to read: “Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.)”
- △ Consolidate item 36500 under item 30324. (Item 36500 was assigned to the Urology Clinical Committee. This recommendation will be referred to this committee or to the Urological Society of Australia and New Zealand directly.)

Rationale

The recommendations focus on encouraging best practice and simplifying the MBS to ensure high-value care for patients.⁸ They are based on the following observations.

- △ There is overlap between the item descriptors for items 30321 and 30323. The items are differentiated based on the clinician’s judgment of whether the procedure was “complex and extensive,” which warrants an extra \$457. The Committee acknowledged that the “complex and extensive” procedure (item 30323) is the most appropriate treatment in the majority of circumstances, but that the item’s schedule fees encourage clinicians to bill the “complex and extensive” item number regardless. This can be seen in the MBS data: service volume for the less expensive item (30321) has declined by an average of 9 per cent per year over the last five years, accounting for just 13 per cent of the service volume for item 30323 in FY2014/15; the more expensive item (30203), meanwhile, has been growing modestly by 1.5 per cent year on year for the last five years.[2]
- △ There is overlap between items 30324 and 36500, which creates confusion for providers and leads to inconsistent billing and treatment of patients. The Committee agreed that item 30324 aligns with best practice, and that consolidating item 36500 under item 30324 would encourage best-practice patient care and have a minimal impact on access. The Committee noted that item 36500 allows for the removal of normal adrenal glands and suggested that there should be no additional rebate for removing normal adrenal tissue when performed as part of nephrectomy. Only 56 procedures were performed under item 36500 in FY2014/15.

⁸ Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.

5.6 Administration of thyrotropin alfa-rch: Item 12201

Table 9: Item introduction table for item 12201

Item	Descriptor [date last amended]	Schedule fee	Services FY2014/15	Benefits FY2014/15	Services 5 year annual avg. growth
12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness—applicable once only in a 12 month period. [2004]	\$2,392.90	184	\$427, 895	2.2%

Recommendation 9

- △ Change the item descriptor to make the nuclear scan (item 61426) optional, rather than obligatory. The proposed wording change is provided below, highlighted in italics.
 - Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), *and arranging diagnostic imaging as necessary and pathology services under item 66650.*
- △ It should be noted that the Committee is proposing the creation of new items that may be used instead of item 66650, which may make it necessary to amend the numbering of this item if adopted.
- △ The Committee also wishes to refer this item to the Nuclear Medicine Working Group to review whether other indications in the item descriptor should be removed.

Rationale

The recommendations focus on encouraging best practice and are based on the following observations.

- △ The Committee agreed that the associated nuclear scan (item 61426) is not always clinically required and should be optional, rather than a mandatory component of the service. This is in line with Recommendations 66 and 67 of the 2015 American Thyroid Association’s Management Guidelines for adult patients with thyroid nodules and differentiated thyroid cancer.[7]
- △ Pathology quantitation (item 66650) or the equivalent is necessary and its requirement should remain.[7]
- △ The cost of the drug should continue to be included. Although it accounts for the large majority of the schedule fee (\$1,802.17), the drug is used as part of a diagnostic test and cannot be included on the PBS, as per PBS rules.

- △ The Committee noted that although the item should have restrictions to ensure that only the appropriate patients receive services under this item, the current indications could be reduced to allow access to a wider patient group. This decision would require an extensive review of the existing guidelines, literature and data, including an appropriate cost–benefit analysis of the outcomes. The Committee noted that the Nuclear Medicine Working Group may wish to review this item, and that a process should perhaps be created to conduct such a review, if the working group agrees it is necessary.

5.7 Broader issues

During the review of the thyroid and parathyroid-related surgical items, the Committee noted that a large number of surgeons perform relatively few thyroid and parathyroid surgical procedures each year, according to MBS data. In FY2014/15, for example, 56 per cent of the 455 thyroid and parathyroid surgical providers performed five or fewer MBS-funded procedures.[18] In light of evidence from the international literature, which suggests that volume is correlated with outcomes, the Committee created a working group to explore this further.

Based on the findings of this working group, the Committee concluded that this data is incomplete, and that it can only serve as a rough proxy for service volumes as it does not include procedures conducted on public patients in the public hospital system, where many surgeons also practise. The Committee also emphasised that low volumes are to be expected in the Australian setting, where many regionally-based surgeons provide patients with access to a broad range of high-quality local services. Many of their most qualified colleagues who practise in regional and remote areas perform a relatively low number of thyroid and parathyroid surgical procedures each year without any known adverse impact on patient outcomes. Furthermore, although certain literature does indicate that volumes are correlated with outcomes, particularly for higher complexity procedures,[19]–[24] this evidence is not universal for all surgical procedures. There is also no local evidence that patients in regional Australia who undergo surgery performed by surgeons with lower annual volumes have poorer outcomes.

Nonetheless, the Committee agreed that this data is important and should be supplied to the Royal Australasian College of Surgeons and relevant hospitals that are responsible for the development of professional standards and credentialing of individual surgeons. The Committee also noted that all surgeons, regardless of location, should recognise the circumstances when referral to a colleague with greater skills is warranted. It also noted that consumers should be advised of the importance of asking their surgeons about their experience and surgical outcomes, particularly complication rates, to assist them in making informed decisions about their planned surgery.

6. Stakeholder impact statement

Patients and providers are expected to benefit from the recommendations, as fewer items and clearer item descriptors (supported by explanatory notes) will minimise confusion for providers and incentivise best-practice clinical care for patients. Where items have been recommended for consolidation or deletion, an equivalent item has been highlighted that can absorb the service volume for a comparable MBS fee.

7. References

- [1] A. Elshaug, 'Appropriate Use Criteria', 2016.
- [2] M. R. U. Department of Health Australia, 'MBS data', 2016.
- [3] A. B. of Statistics, 'Australian Demographic Statistics', 3101.0 - Australian Demographic statistics Jun 2010 and Jun 2015. [Online]. Available: [http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3101.0Main Features1Jun 2015?opendocument&tabname=Summary&prodno=3101.0&issue=Jun 2015&num=&view=](http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3101.0MainFeatures1Jun2015?opendocument&tabname=Summary&prodno=3101.0&issue=Jun2015&num=&view=). [Accessed: 25-Apr-2016].
- [4] R. S. Bahn, H. B. Burch, D. S. Cooper, R. S. Bahn, H. B. Burch, and D. S. Cooper, 'ATA / AACE Guidelines HYPERTHYROIDISM AND OTHER CAUSES OF THYROTOXICOSIS : MANAGEMENT GUIDELINES OF THE AMERICAN THYROID ASSOCIATION AND AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS HYPERTHYROIDISM AND OTHER CAUSES OF THYROTOXICOSIS : MANAGEMENT GUID', vol. 17, no. 3, pp. 1–65, 2011.
- [5] K. L. Snook, P. L. H. Stalberg, S. B. Sidhu, M. S. Sywak, P. Edhouse, and L. Delbridge, 'Recurrence after total thyroidectomy for benign multinodular goiter.', *World J. Surg.*, vol. 31, no. 3, pp. 593–8; discussion 599–600, Mar. 2007.
- [6] M. R. U. Department of Health, 'MBS data'.
- [7] B. R. Haugen, E. K. Alexander, K. C. Bible, G. M. Doherty, S. J. Mandel, Y. E. Nikiforov, F. Pacini, G. W. Randolph, A. M. Sawka, M. Schlumberger, K. G. Schuff, S. I. Sherman, J. A. Sosa, D. L. Steward, R. M. Tuttle, and L. Wartofsky, '2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer: The American Thyroid Association Guidelines Task Force on Thyroid Nodules and Differentiated Thyroid Cancer.', *Thyroid*, vol. 26, no. 1, pp. 1–133, Jan. 2016.
- [8] M. R. U. Department of Health Australia, 'MBS data - Cognos', 2016.
- [9] O. Norlén, K. C. Wang, Y. K. Tay, W. R. Johnson, S. Grodski, M. Yeung, J. Serpell, S. Sidhu, M. Sywak, and L. Delbridge, 'No need to abandon focused parathyroidectomy: a multicenter study of long-term outcome after surgery for primary hyperparathyroidism.', *Ann. Surg.*, vol. 261, no. 5, pp. 991–6, May 2015.
- [10] J. Norman, J. Lopez, and D. Politz, 'Abandoning unilateral parathyroidectomy: why we reversed our position after 15,000 parathyroid operations.', *J. Am. Coll. Surg.*, vol. 214, no. 3, pp. 260–9, 2012.
- [11] A. Chitale, P. Musonda, A. M. McGregor, and K. K. Dhatariya, 'Determining the utility of the 60 min cortisol measurement in the short synacthen test.', *Clin. Endocrinol. (Oxf.)*, vol. 79, no. 1, pp. 14–9, Jul. 2013.
- [12] C. P. Woods, N. Argese, M. Chapman, C. Boot, R. Webster, V. Dabhi, A. B. Grossman, A. A. Toogood, W. Arlt, P. M. Stewart, R. K. Crowley, and J. W. Tomlinson, 'Adrenal suppression in patients taking inhaled glucocorticoids is highly prevalent and management can be guided by morning cortisol', *Eur. J. Endocrinol.*, vol. 173, no. 5, pp. 633–642, 2015.
- [13] W. J. Inder and P. J. Hunt, 'Glucocorticoid replacement in pituitary surgery: guidelines for perioperative assessment and management.', *J. Clin. Endocrinol. Metab.*, vol. 87, no. 6, pp. 2745–50, Jun. 2002.
- [14] T. Deutschbein, N. Unger, K. Mann, and S. Petersenn, 'Diagnosis of secondary adrenal insufficiency in patients with hypothalamic-pituitary disease: Comparison between serum and

- salivary cortisol during the high-dose short synacthen test', *Eur. J. Endocrinol.*, vol. 160, no. 1, pp. 9–16, Jan. 2009.
- [15] W. S. Yo, L.-M. Toh, S. J. Brown, W. D. Howe, D. E. Henley, and E. M. Lim, 'How good is a morning cortisol in predicting an adequate response to intramuscular synacthen stimulation?', *Clin. Endocrinol. (Oxf)*, vol. 81, no. 1, pp. 19–24, Jul. 2014.
- [16] C. W. Le Roux, K. Meeran, and J. Alaghband-Zadeh, 'Is a 0900-h serum cortisol useful prior to a short synacthen test in outpatient assessment?', *Ann. Clin. Biochem.*, vol. 39, no. Pt 2, pp. 148–50, Mar. 2002.
- [17] F. M. Gioacchini, M. Alicandri-Ciufelli, S. Kaleci, G. Magilulo, L. Presutti, and M. Re, 'Clinical presentation and treatment outcomes of thyroglossal duct cysts: a systematic review', *Int. J. Oral Maxillofac. Surg.*, vol. 44, no. 1, pp. 119–26, 2015.
- [18] M. R. U. Department of Health Australia, 'MBS data - Q20320', 2016.
- [19] C. D. Adkisson, G. M. Howell, K. L. McCoy, M. J. Armstrong, M. L. Kelley, M. T. Stang, J. M. Joyce, S. P. Hodak, S. E. Carty, and L. Yip, 'Surgeon volume and adequacy of thyroidectomy for differentiated thyroid cancer', *Surgery*, vol. 156, no. 6, pp. 1453–1460, Dec. 2014.
- [20] M. M. Chowdhury, H. Dagash, and A. Pierro, 'A systematic review of the impact of volume of surgery and specialization on patient outcome', *British Journal of Surgery*, vol. 94, no. 2, pp. 145–161, Feb-2007.
- [21] A. Duclos, J.-L. Peix, C. Colin, J.-L. Kraimps, F. Menegaux, F. Pattou, F. Sebag, S. Touzet, S. Bourdy, N. Voirin, and J.-C. Lifante, 'Influence of experience on performance of individual surgeons in thyroid surgery: prospective cross sectional multicentre study', *BMJ*, vol. 344, no. jan10 2, pp. d8041–d8041, Jan. 2012.
- [22] M. A. Adam, S. Thomas, L. Youngwirth, T. Hyslop, S. D. Reed, R. P. Scheri, S. A. Roman, and J. A. Sosa, 'Is There a Minimum Number of Thyroidectomies a Surgeon Should Perform to Optimize Patient Outcomes?', *Ann. Surg.*, Mar. 2016.
- [23] J. W. Serpell, J. C. Lee, M. J. Yeung, S. Grodski, W. Johnson, and M. Bailey, 'Differential recurrent laryngeal nerve palsy rates after thyroidectomy', *Surg. (United States)*, vol. 156, no. 5, pp. 1157–1166, 2014.
- [24] J. Lee, S. Fraser, A. Glover, and S. Sidhu, 'Prospective evaluation of the utility of routine neuromonitoring for an established thyroid surgical practice.', *ANZ J. Surg.*, Apr. 2016.

Appendix A - Recommendations list

Item	Current descriptor	Recommendation
12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness— applicable once only in a 12 month period.	Change
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented.	Change
30296	Thyroidectomy, total. (Anaes.) (Assist.)	Change
30297	Thyroidectomy following previous thyroid surgery. (Anaes.) (Assist.)	Change
30306	Total hemithyroidectomy. (Anaes.) (Assist.)	Change
30308	Bilateral subtotal thyroidectomy. (Anaes.) (Assist.)	Change
30309	Thyroidectomy, subtotal for thyrotoxicosis. (Anaes.) (Assist.)	Delete
30310	Thyroid, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy. (Anaes.) (Assist.)	Change
30313	Thyroglossal cyst, removal of. (Anaes.) (Assist.)	Delete
30314	Thyroglossal cyst or fistula or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone. (Anaes.) (Assist.)	Change
30315	Parathyroid operation for hyperparathyroidism. (Anaes.) (Assist.)	Change
30317	Cervical reexploration for recurrent or persistent hyperparathyroidism. (Anaes.) (Assist.)	Change
30318	Mediastinum, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy). (Anaes.) (Assist.)	Change
30320	Mediastinum, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy). (Anaes.) (Assist.)	Change
30321	Retroperitoneal neuroendocrine tumour, removal of. (Anaes.) (Assist.)	Change
30323	Retroperitoneal neuroendocrine tumour, removal of, requiring complex and extensive dissection. (Anaes.) (Assist.)	Change
30324	Adrenal gland tumour, excision of. (Anaes.) (Assist.)	Change

Appendix B - Glossary

Term	Description
ASUM	Australasian Society for Ultrasound in Medicine
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	Describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes, (ii) the consolidation of item numbers, and (iii) splitting item numbers (e.g., splitting the current services provided across two or more items).
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
DIAS	Diagnostic Imaging Accreditation Scheme
FY	Financial year
GP	General Practitioner
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	The use of an intervention that evidence suggests confers little benefit or no benefit to patients; or where the risk of harm from the intervention exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.
LSPN	Location Specific Practice Number
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
MSAC	Medical Services Advisory Committee
Multiple operation rule	A rule governing the amount of Medicare benefit payable for multiple operations performed on a patient on the one occasion. In general, the fees for two or more operations are calculated by the following rule: <ul style="list-style-type: none"> – 100 per cent for the item with the greatest schedule fee. – Plus 50 per cent for the item with the next greatest schedule fee. – Plus 25 per cent for each other item.
Multiple services rules	A set of rules governing the amount of Medicare benefit payable for multiple services provided to a patient at the same attendance (same day).
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, these will need to go through MSAC. It is worth noting that the implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (e.g., references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services/ items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
OGCT	Oral glucose challenge test
OGTT	Oral glucose tolerance test
PBS	Pharmaceutical Benefits Scheme
PCC	Pathology Clinical Committee

Term	Description
RACGP	Royal Australian College of General Practitioners
The Committee	Endocrinology Clinical Committee
The Taskforce	MBS Review Taskforce

Appendix C - Summary for consumers

This table describes the medical service, recommendations of the Clinical Experts and why the recommendation has been made.

Recommendation 1: Thyroidectomy items 30296 and 30309

Item	What it does	Committee recommendation	What would be different	Why
30296 and 30309	These items cover total and subtotal thyroidectomies, which is the surgical removal of all or part of the thyroid gland.	Consolidate item 30309 under item 30296, leaving the descriptor for item 30296 unchanged and adding clearer explanatory notes.	Procedures previously performed under item 30309 would now be performed as a total thyroidectomy under item 30296.	To improve clinical quality and provide better guidance for thyroidectomies explaining when they should be used.

Recommendation 2: Thyroidectomy item 30306

Item	What it does	Committee recommendation	What would be different	Why
30306	Total hemithyroidectomy, which is the removal of one of the lobes (and part of the isthmus) of the thyroid gland.	Update the explanatory notes to provide clearer guidance on the appropriate use of hemithyroidectomies in line with best clinical practice.	Providers are encouraged to consider best clinical practice standards and where possible, use item 30306 instead of 30310.	To align the use of total hemithyroidectomies with best clinical practice and is supported by the American Thyroid Association's Management Guidelines.

Recommendation 3: Thyroidectomy items 30308 and 30310

Item	What it does	Committee recommendation	What would be different	Why
30308 and 30310	These items cover partial thyroid gland removal including bilateral subtotal thyroidectomies and unilateral subtotal thyroidectomies or the equivalent partial thyroidectomy.	Consolidate items 30308 and 30310 into one item number. Update the explanatory notes to provide clinicians with better guidance on the use of these items.	These items would be consolidated into one item with a proposed descriptor of 'Partial or subtotal thyroidectomy (Anaes.) (Assist.)' As explanatory notes are currently not provided, this would better guide providers on the appropriate use of these item numbers.	This recommendation focuses on modernising and simplifying the item numbers to reflect best clinical practice for patients.

Recommendation 4: Thyroidectomy item 30297

Item	What it does	Committee recommendation	What would be different	Why
30297	This item covers a thyroidectomy (surgical removal of the thyroid gland) following previous thyroid surgery.	Add explanatory notes to this item number to provide better guidance for providers.	Explanatory notes would be provided to ensure best practice guidelines are followed in using this item number.	To improve clinical quality and provide better guidance for thyroidectomies explaining when it's appropriate to be used.

Recommendation 5: Parathyroid items 30315, 30317-8 and 30320

Item	What it does	Committee recommendation	What would be different	Why
30315, 30317-8 and 30320	These items cover removal of the parathyroid gland to treat an overactive gland (hyperparathyroidism).	Change item descriptors for all four items to promote best practice and limit inappropriate co-claiming. Change item number 30318 to 30316 to make the order of item numbers more intuitive.	Updated item descriptors would be clearer and reflect current modern use of the items and address any intended or unintended misuse.	This recommendation aims to simplify these item numbers to reflect best clinical practice for ease of use by practitioners and address potential misuse in co-claiming.

Recommendation 6: Synacthen stimulation test item 30097

Item	What it does	Committee recommendation	What would be different	Why
30097	This test checks the function of the adrenal gland, to see whether a patient is producing enough steroid hormone (cortisol).	Change the item descriptor to require a basal cortisol quantitation prior to a Synacthen stimulation test and add clearer explanatory notes.	Low-value testing would be addressed by requiring the use of basal cortisol measurements prior to performing a Synacthen stimulation test.	Growth and service volume of this item showed a likely indication of over-testing. The additional requirement to undertake a basal cortisol quantitation along with clearer rules describing when this test is appropriate will address any over-use and provide better clinical guidance.

Recommendation 7: Thyroglossal cyst items 30313 and 30314

Item	What it does	Committee recommendation	What would be different	Why
30313 and 30314	Removal of thyroglossal cysts(a cyst in the neck close to the thyroid gland).	Delete 30313 from the MBS and direct providers to instead use item 30314 and update the item descriptor for 30314.	Patients will receive a more effective and up-to-date treatment which has a lower cyst recurrence rate.	Item 30313 is obsolete and doesn't reflect best practices. The use of item 30314 improves clinical quality and provides a better quality of service to patients.

Recommendation 8: Tumour removal items 30321, 30323-4 and 36500

Item	What it does	Committee recommendation	What would be different	Why
30321, 30323-4 and 36500	Removal adrenal gland tumours and other rare tumours located in the abdomen that produce hormones.	Consolidate item 30321 into 30323 and item 36500 into 30324. Update item descriptors for items 30323 and 30324 to provide better clinical guidance.	Billing would be simplified for providers; patients would see little if any change in treatment.	The Committee believes this is still a clinically relevant treatment and sees no concerns with consolidating the items to simplify the MBS and provide consistent billing and treatment to patients.

Recommendation 9: Administration of thyrotropin alfa-rch item 12201

Item	What it does	Committee recommendation	What would be different	Why
12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch in the management of thyroid cancer.	Change the item descriptor to make the nuclear scan (item 61426) optional rather than obligatory.	Providers would have the option to perform the associated nuclear scan if deemed appropriate as part of this service to patients.	The Committee recommends to the Nuclear Medicine Clinical Committee that the associated nuclear scan is not always clinically required and should be optional instead of mandatory for this service. This is in line with best practice and recommendations 66 and 67 of the 2015 American Thyroid Association's Management Guidelines.