



Australian Government

Medical Services Advisory Committee

Public Summary Document

Report to the Medical Services Advisory Committee on Application No. 1180r – Review of Medicare Benefits Schedule (MBS) items for the surgical treatment of obesity

MBS items considered: 31569, 31572, 31575, 31578, 31581, 31584, 31587 and 31590.

Date of MSAC consideration: 28-29 March 2018

Context for decision: MSAC makes its advice in accordance with its Terms of Reference, see the [MSAC Website](#).

1. Purpose

The purpose of the report presented to the Medical Services Advisory Committee (MSAC) was to inform members of the real world impacts on the outcomes of Application 1180r. The MSAC uses this information to ensure that the new and amended items resulting from this application are being used as intended.

2. MSAC's advice

After consideration of various MBS data for the surgical treatment of obesity (MBS items 31569, 31572, 31575, 31578, 31581, 31584, 31587 and 31590) - MSAC Application 1180r, MSAC recommended a comprehensive review of the management of obesity and obesity-related MBS items. MSAC suggested that such a review take into consideration surgical interventions, dietary and physical activity programmes, psychological therapies, psychiatric therapies, allied health and pharmacotherapies.

MSAC recommended the development and implementation of a nationally recognised pathway for patients to access bariatric surgery and the review of clinical practice guidelines for obesity.

MSAC also recommended collaboration between the private and public health systems to achieve solutions that can improve accessibility to bariatric surgery services.

MSAC advised that the MBS items for bariatric surgery be modified to entail restrictions that prevent the co-claiming of laparoscopic items with bariatric surgery items.

3. Summary of consideration and rationale for MSAC's advice

MSAC considered the impacts of the outcome of MSAC Application 1180r for the surgical treatment of obesity by examining various MBS data. This included MBS items 31569,

31572, 31575, 31578, 31581, 31584, 31587 and 31590, which are all bariatric surgery services (hereafter described as all bariatric MBS items).

MSAC recalled that these items had undergone a review for the 54th MSAC meeting in November 2011 and that MSAC recommended these items be amended to remove ambiguity and rectify co-claiming issues. After thorough stakeholder engagement, the amended items were implemented on the MBS on 1 July 2013.

Six of the bariatric MBS items (items 31569, 31572, 31575, 31578, 31581 and 31584) cover primary bariatric surgery services (including restrictive procedures such as adjustable gastric band, sleeve gastrectomy and gastroplasty without plication, and malabsorptive procedures such as Roux-en-Y gastric bypass and biliopancreatic diversion). The other two items, 31587 and 31590, relate to the adjustment or maintenance of the gastric band used in laparoscopic gastric banding procedures.

MSAC noted that 116,748 bariatric surgery services (all bariatric MBS items) were provided in the financial year 2013–14 and 91,136 services in the financial year 2016–17. The utilisation of primary bariatric surgery services in the financial year 2013-14 was 17,762 and in 2016–17, 20,139 services were claimed. MSAC noted that the volume of primary bariatric surgery services had experienced linear upward growth in utilisation over the review period. MSAC noted that the cost in benefits paid for the financial year 2016–17 was \$22 million for all bariatric MBS items, and over \$86 million in total benefits were paid for all bariatric MBS items for financial years 2013-17.

MSAC noted that the majority of services were claimed in Queensland, Victoria and New South Wales (NSW), with these three states accounting for more than 90% of the total services. However, MSAC noted that Queensland and Western Australia had the highest rate of bariatric surgery services per capita.

MSAC noted that for item 31575 (sleeve gastrectomy), the most commonly claimed primary bariatric surgical item, service volumes are highest in NSW, followed by Queensland, with 16,486 and 15,262 services performed since implementation, respectively.

MSAC noted that although obesity prevalence is higher in men, the majority of bariatric surgery services were for females. MSAC noted the majority of gastric bypass Roux-en-Y services (item 31572), removal/replacement of gastric band services (item 31584) and adjustment of gastric band services (item 31587), were for females ages 45–54. MSAC noted that the majority of sleeve gastrectomy services (item 31575) were for females aged 35–44.

MSAC considered that there were noticeable variations between the 25th and 95th percentiles of fees charged for bariatric surgery services. MSAC noted that there was a top 95th percentile charge of \$6000 for sleeve gastrectomy (item 31575, schedule fee \$849.55).

MSAC noted that bulk billing rates for all bariatric MBS items were low at 9% in the financial year 2016–17; and in 2014-15 it was estimated that significantly less than 10% of bariatric services were performed on public patients in public hospitals. MSAC noted that for uninsured patients, there may be an out-of-pocket cost of up to \$20,000 for bariatric surgery (including costs of associated care such as anaesthetists' fees, theatre costs and hospital stays).

MSAC noted that in the financial year 2016–17, 310 practitioners provided primary bariatric surgery services (all bariatric MBS items except 31587 and 31590) and 226 practitioners provided MBS item 31575 (sleeve gastrectomy). 50% of these 226 practitioners provided over 94% of the total services rendered under item 31575 in 2016-17.

MSAC noted that MBS items 105 (consultation) and 30393 (laparoscopic division of adhesions) were the most commonly co-claimed items with bariatric surgery services (all bariatric MBS items). MSAC also noted that there were incidences of co-claiming with MBS item 30390 (diagnostic laparoscopy) and MBS item 30391 (laparoscopy with biopsy). MSAC considered that the current MBS items for bariatric surgeries inherently include the use of laparoscopic procedures in the fee and considered the co-claiming of laparoscopic items with bariatric surgery items to be inappropriate. MSAC noted that as of 1 November 2017, MBS items 105, 116 and 119 can no longer be claimed on the same day as a group T8 item with a schedule fee of \$300 or more.

MSAC acknowledged that there were barriers to accessing bariatric surgery services. These barriers included long wait times for elective surgery for public patients in public hospitals and high out-of-pocket costs in the private sector. MSAC noted an emerging trend of patients accessing their superannuation benefits early to pay for medical services including bariatric surgery, and acknowledged the Department of Health's report that the relevant legislation was currently under review by the Treasury.

MSAC acknowledged that the treatment of obesity requires a complex multidisciplinary team approach that incorporates physical, psychological, psychiatric, social, lifestyle and pharmacological care. MSAC acknowledged that there may be a lack of follow-up care for bariatric surgical patients. MSAC recognised that general practitioners (GPs) are likely to end up being responsible for the care of these patients due to this lack of co-ordinated follow-up care and they may need to be upskilled to provide appropriate long-term support.

MSAC recommended a comprehensive review of obesity management services currently available in Australia, including obesity-related MBS items. MSAC acknowledged that obesity is a complex condition where alterations in policy could potentially have unintended flow-on effects and thus a holistic approach should be undertaken. MSAC suggested that the scope of this review should encompass surgical interventions, dietary and physical activity programmes, psychological therapies, psychiatric therapies, allied health and pharmacological therapies. MSAC noted that there are currently no listed pharmacological agents for obesity on the PBS. MSAC also recommended to include into the scope of the review the possibility of GP-led care, which would include medical and psychological care, referral to bariatric surgery, and follow-up care post-bariatric surgery.

MSAC also advised the development and implementation of a nationally recognised pathway to:

- improve patient access to bariatric surgery services;
- ensure that patients would receive comprehensive care (including adequate follow-up support); and
- ensure bariatric surgery is clinically appropriate for the patient.

MSAC suggested identifying any existing pathways of care that would assist in developing a model of care. MSAC acknowledged that a tertiary facility in Victoria that specialises in the management of obesity was mentioned as a potential source of information for clinical care and clinical patient pathways.

MSAC also recommended the development and implementation of a quality assurance program for practitioners to ensure consistency in the standards of bariatric surgeries.

MSAC noted that the Australian Government currently funds the Bariatric Surgery Registry that collects data from patients who have received bariatric surgery and that the registry is now running into its fifth year. MSAC advised that more information from this data set will

be available as the registry matures. MSAC requested that the registry also collect meaningful information on outcomes (such as prevalence in cardiovascular diseases and metabolic diseases) and complications associated with bariatric surgery.

MSAC suggested that the Australian Commission on Safety and Quality Health Care may be able to conduct an analysis and review on regional variations in the uptake and utilisation of bariatric surgery services.

MSAC acknowledged the need to improve accessibility to bariatric surgery services, particularly for disadvantaged patients who may be from lower socioeconomic backgrounds and may not have the access to funds to cover out-of-pocket expenses.

MSAC advised that a systematic approach, across the public and private health systems, may assist to improve accessibility to bariatric surgery services for eligible patients in a cost-effective manner.

3. Methodology

An application is selected for consideration if the resulting new item(s) and/or item amendment(s) have been on the MBS for approximately 24 months or longer or if there were particular concerns about utilisation such that MSAC requested to consider it earlier. The specific applications for each MSAC meeting are selected by the MSAC Executive which is composed of the chairs of MSAC and its sub-committees.

A report on the utilisation is developed by the department with information on a number of metrics including; state variation, patient demographics, services per patient, practitioner's providing the service, data on fees and co-claiming of services. The number of metrics included in a report is dependent on the annual service volume for the MBS item(s) under consideration i.e. an item with very low utilisation will have less data to analyse. Where service volumes are too low, information is suppressed to protect patient privacy.

Where possible, the report compares data on real world utilisation to the assumptions made during the MSAC assessment. Most of these assumptions are drawn from the assessment report.

Relevant stakeholders are provided an opportunity to comment on the findings in the report before it is presented to the MSAC. It is intended that stakeholders are given at least three weeks to consider the reports.

The stakeholder version of the report does not contain information on assumptions from the MSAC consideration if this information is not already publicly available. This is to protect the commercial in confidence of the original applicants. The same principle is applied to this document.

Once MSAC has considered the report, its advice is made available online at the [MSAC Website](#).

4. Surgical treatment of obesity in Australia's health system

The National Health and Medical Research Council's Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia (2013) recommend that bariatric surgery, in combination with appropriate follow-up, is the most effective treatment for patients with type III obesity (BMI 40.00 or more). Bariatric surgery is also recommended for patients with a BMI of 35 or more (type II obesity), with other medical co-morbidities. Bariatric patients often present with a multitude of co-

morbidities, such as type-2 diabetes and cardiovascular disease. Bariatric surgery is the only current treatment that has been shown to achieve major and durable weight loss, which, as evidence suggests, can lead to total or partial control of related co-morbidities¹. In 2008 it was estimated that the total financial costs of obesity, including obesity related expenditure in Australia was \$8.3 billion²

At its 54th meeting in November 2011, the MSAC agreed there is high clinical need for bariatric surgery to address obesity as a growing public health concern, but that long term data was lacking. It was noted at this meeting the need for a register for patients who have undergone bariatric surgery. The bariatric surgery registry (BSR) was established in 2009 and a pilot registry rolled out in 2012. The BSR is managed by Monash University with support from the Australian and New Zealand Metabolic and Obesity Surgery Society. In June 2017 the BSR released their fifth annual report. For the past four years the BSR has been funded predominantly by the Commonwealth Government and the aim of the registry is to measure safety and quality outcomes for patients undergoing bariatric surgery across public and private hospitals in Australia and New Zealand. Through ongoing patient follow-up, the registry collects information on patient weight loss, change in diabetes status and problems related to the surgery, both in the short and long term. It is not possible yet to draw an accurate picture of the outcomes for bariatric patients from the registry, as a longer period is required to analyse the long term effects on patients.

According to the Australian Bureau of Statistics, in 2014-15 almost two thirds of adult Australians were overweight or obese (36% overweight, 28% obese). Of the 28% of obese Australians a potential 9% would qualify for bariatric surgery (class II and III obesity). This represents approximately 1.5 million people. Table 1 represents the total bariatric separations performed in 2014-15, the total primary (items 31569-31584) MBS listed bariatric surgical services claimed and the total publicly funded bariatric separations within the same year.

Table 1: Total hospital bariatric surgery separations and total primary MBS bariatric surgical services 2014-15

Total separations	22,713
Total MBS services for primary (items 31569-31584) bariatric surgical procedures	19,154

Source: Australian Institute of Health and Welfare – Weight loss surgery in Australia 2014-15, Medicare Statistics, 2017.

The Australian Institute of Health and Welfare (AIHW) report on Weight loss surgery in Australia 2014-15 reports that during this year 2,700 bariatric separations were performed in public hospitals, representing approximately 10% of total bariatric separations. However, this figure includes both public and private patients who have received care in public hospitals and therefore the true figure of how many public patients in public hospitals who received bariatric surgery in 2014-15 would likely be much lower than 10%. The department is aware that wait times for publicly funded bariatric surgery in Australia can be significant with some patients reporting waiting over 7 years. This reflects that access is extremely limited in the public hospital system and that the distribution of bariatric surgery is not evenly associated with clinical need. This is a broader policy dilemma beyond the scope of this paper.

According to anecdotal evidence, out of pocket costs for uninsured private patients undergoing bariatric surgery can be more than \$20,000. According to Hospital Casemix Protocol 1, in 2015-16, the average insured bariatric surgical patient was covered for roughly

¹ O'Brien P, Brown W and Dixon J. 2005. Obesity, weight loss and bariatric surgery. *Medical Journal of Australia*. 183(6): 310-314.

² Australian Bureau of Statistics. 2004–05. National Health Survey: summary of results, Australia. 2006. *Australian Bureau of Statistics*: Canberra.

\$10,400 by their private health insurer, resulting in a significant out of pocket gap fee. The Department of Health has increasingly become aware of patients opting to access their superannuation to pay for the out of pocket costs associated with medical services. These patients are applying to either cover the gap between the total fee and their health insurance benefits, as well as for uninsured patients who must pay the total costs (>\$20,000) associated with their procedure. The Department of the Treasury are currently reviewing the rules around the early access to superannuation scheme on compassionate grounds.

5. Results

Utilisation

The utilisation data of bariatric surgery items 31569-31590 (8) reports 116,748 services rendered in year 1, and 91,136 services in year 4 (Table 2). However, for primary bariatric surgical services 31569-31584 (6), the utilisation was 17,762 services for year 1 and 23,828 in year 4 (Table 3). The increase in service volumes for primary items is largely due to the significant increase in the utilisation of item 31575 (sleeve gastrectomy). Further, of note is the decrease in claiming of item 31587 (adjustment of a gastric band).

MBS expenditure on subsidising bariatric surgery continues to grow. In 2005 MBS expenditure on bariatric surgery was \$6.3 million and \$19.3 million in 2009. These figures are based on MBS bariatric surgery items pre-implementation of new and amended items in 2013. The total benefits paid for MBS items 31569-31590 (8) from 2013-14 to 2016-17 was over \$86 million. The most recent financial year (2016-17) saw over \$22 million paid in MBS benefits for bariatric services.

Tables 4-9 represent state and territory service volumes for bariatric surgical items 31569, 31572, 31575, 31584, 31587 and 31590. This is both primary and secondary bariatric procedures, excluding items 31578 and 31581. These two items have been excluded as service numbers are too low to conceal patient confidentiality. Item 31578 is for gastroplasty, primarily vertical banded gastroplasty (otherwise known as stomach stapling) and item 31581 is for gastric bypass by biliopancreatic diversion. The low utilisation of these items is likely a reflection of providers preferring surgical techniques such as sleeve gastrectomy and adjustable gastric band over these items. Gastric plication is specifically excluded under item 31578 which has also likely kept utilisation low. The department is aware of an increasing number of providers in Australia offering endoscopic sleeve gastroplasty. The department has communicated to the profession that these surgical techniques require an MSAC assessment to inform whether or not they should also attract MBS rebates.

For some items, service volume data for the Northern Territory, Tasmania and the Australian Capital Territory has been combined with Queensland, Victoria and New South Wales, respectively. In all of these instances, the data in Queensland, Victoria and New South Wales accounts for at least 90% of the total for that combined states column.

For item 31575 (sleeve gastrectomy), the most commonly claimed primary bariatric surgical item, service volumes are highest in New South Wales, followed by Queensland, with 16,486 and 15,262 services performed since implementation, respectively.

Service volumes across all items are significantly lower in the Australian Capital Territory and the Northern Territory.

Table 2: Service volumes for bariatric surgery items, 2013-14 – 2016-17

Item no.	Year 1 2013-14	Year 2 2014-15	Year 3 2015-16	Year 4 2016-17	Total
31569	4097	2,830	2,181	1,512	10,620
31572	882	1,323	2,029	2,424	6,658
31575	9,177	11,326	13,617	15,980	50,100
31578	55	39	58	122	274
31581	26	24	59	101	210
31584	3,525	3,612	3,592	3,689	14,418
31587	98,266	88,027	79,495	66,899	332,687
31590	720	704	506	409	2,339
Total	116,748	107,885	101,537	91,136	417,306

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 3: Service volumes for primary bariatric surgical items, 2013-14 – 2016-17

Item no.	Year 1 2013-14	Year 2 2014-15	Year 3 2015-16	Year 4 2016-17	Total
31569	4097	2,830	2,181	1,512	10,620
31572	882	1,323	2,029	2,424	6,658
31575	9,177	11,326	13,617	15,980	50,100
31578	55	39	58	122	274
31581	26	24	59	101	210
31584	3,525	3,612	3,592	3,689	14,418
Total	17,762	19,154	21,536	23,828	82,280

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Tables 4-9: State and Territory service volumes for MBS listed bariatric services 31569, 31572, 31575, 31584, 31587 and 31590; 2013-14 to 2016-17 (date of service)

Table 4: Item 31569, State/Territory

	NSW & ACT	VIC	QLD	SA	WA	TAS	NT	Total
2013/2014	630	1,387	527	320	807	348	78	4097
2014/2015	393	1,124	356	152	448	287	70	2830
2015/2016	327	893	241	99	315	253	53	2181
2016/2017	167	652	177	50	264	172	30	1512
Total	1,517	4,056	1,301	621	1,834	1,060	231	10,620

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 5: Item 31572, State/Territory

	NSW & ACT	VIC & TAS	QLD & NT	SA	WA	Total
2013/14	170	233	309	137	33	882
2014/2015	269	340	391	200	123	1,323
2015/2016	400	495	556	265	313	2,029
2016/2017	507	556	744	286	330	2,423
Total	1,346	1,624	2,000	888	799	6,657

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 6: Item 31575, State/Territory

	NSW	VIC & TAS	QLD & NT	SA	WA	ACT	Total
2013/14	3,109	1,119	2,476	460	1,860	153	9,177
2014/2015	3,721	1,398	3,159	497	2,399	156	11,330
2015/2016	4,602	1,590	4,195	464	2,608	154	13,613
2016/2017	5,054	2,049	5,534	540	2,628	175	15,980
Total	16,486	6,156	15,364	1,961	9,495	638	50,100

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 7: Item 31584, State/Territory

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
2013/14	710	866	815	281	691	127	15	20	3,525
2014/2015	736	885	728	345	773	110	17	18	3,612
2015/2016	739	806	809	293	792	123	11	19	3,592
2016/2017	762	810	830	305	803	141	22	16	3,689
Total	2,947	3,367	3,182	1,224	3,059	501	65	73	14,418

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 8: Item 31587, State/Territory

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
2013/14	12,466	32,944	16,059	7,998	17,216	9,627	1,152	902	98,364
2014/2015	10,369	31,483	13,736	6,678	14,586	9,370	1,149	657	88,028
2015/2016	9,161	28,854	11,980	5,720	11,673	10,354	1,075	604	79,421
2016/2017	6,533	26,501	9,246	4,611	9,541	8,283	1,006	525	66,246
Total	38,529	119,782	51,021	25,007	53,016	37,634	4,382	2,688	332,059

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 9: Item 31590, State/Territory

	NSW & ACT	VIC	QLD & NT	SA	WA	TAS	Total
2013/14	96	254	116	50	109	95	720
2014/2015	103	277	81	70	89	84	704
2015/2016	64	217	56	46	56	67	506
2016/2017	46	169	50	20	47	77	409
Total	309	917	303	186	301	323	2,339

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Data on fee charged

The information provided on fees in Table 10 below is a snapshot of how the items are being claimed in practice for all six primary bariatric surgery items 31569, 31572, 31575, 31578, 31581 and 31584.

Sleeve gastrectomy item, 31575, has a schedule fee of \$849.55. The average fee charged for this item in 2013-14 was \$2,331.66. This increased only slightly to \$2,342.64 in the most recent financial year.

The average fee charged across all six primary items has generally remained stable, with only slight increases each year. Item 31578 (gastroplasty) however, saw a drastic increase in average fee charged in 2016-15 to \$2,483.02. This is an increase of more than double the average fee charged from the year prior. The average fee charged for item 31578 then decreased significantly in 2016-17 to \$1,552.28.

The average fee charged for item 31581 has gradually decreased since implementation, from \$2,691.65 to \$2,278.47.

Figure 1 depicts the average fee charged by providers, as well as the variation in fees charged between the 25th and 95th percentile of providers. It is evident that the highest fee charged was for item 31575 (sleeve gastrectomy), where providers at the 95th percentile charged \$6,000 for this service.

It is important to note that for uninsured patients receiving bariatric surgery from a privately practicing physician, these patients can be out-of-pocket by more than \$20,000. This is inclusive of expenses on top of surgeons' fees, such as anaesthetists' fees, theatre costs and hospital accommodation.

Table 10: Statistics on fees charged for primary bariatric surgical items (31569-31584) from 2013-14 to 2016-17 (date of service).

		31569	31572	31575	31578	31581	31584
2013/14	Average Fee Charged	\$1,646.62	\$1,668.02	\$2,331.66	\$972.23	\$2,691.65	\$2,133.57
	Standard Deviation	\$1,201.76	\$1,230.58	\$1,731.13	\$943.98	\$1,443.37	\$417.96
	Median	\$1,163.45	\$1,400.00	\$1,240.35	\$586.28	\$2,090.60	\$2,107.90
	25th Percentile	\$849.55	\$1,045.40	\$1,122.90	\$424.80	\$1,403.00	\$2,034.35
	95th Percentile³	\$2,400.00	\$4,800.00	\$5,600.00	\$3,849.55	\$4,920.00	\$2,800.00
	Bulk Billed	3.7%	1.20%	3.30%	np	np	0.60%
2014/15	Average Fee Charged	\$1,694.92	\$1,899.49	\$2,286.06	\$1,162.46	\$2,364.03	\$2,190.01
	Standard Deviation	\$1,286.18	\$1,453.98	\$1,778.25	\$1,426.08	\$1,832.42	\$439.80
	Median	\$1,163.45	\$1,431.80	\$1,206.35	\$424.80	np	\$2,107.90

³ The 95th percentile fee charged represents that 95% of the time the fee is below this amount but in 5% of cases, the fee is higher than this.

	25th Percentile	\$849.55	\$1,045.40	\$1,061.90	\$424.80	np	\$2,095.80
	95th Percentile	\$4,450.00	\$5,163.75	\$5,600.00	\$4,892.00	np	\$2,820.95
	Bulk Billed Rate	5.4%	2.30%	4.60%	2.6%	np	0.80%
2015/16	Average Fee Charged	\$1,926.84	\$1,936.24	\$2,301.35	\$2,483.02	\$2,197.46	\$2,196.40
	Standard Deviation	\$1,570.01	\$1,505.26	\$1,808.09	\$2,050.45	\$1,418.43	\$473.93
	Median	\$1,210.63	\$1,431.80	\$1,211.35	\$1,219.05	\$1,531.95	\$2,107.90
	25th Percentile	\$849.55	\$1,045.40	\$1,139.55	\$749.45	\$1,431.80	\$2,102.00
	95th Percentile	\$4,620.00	\$5,545.40	\$5,825.00	\$5,400.00	\$4,640.15	\$3,100.00
	Bulk Billed Rate	5.5%	2.20%	6.20%	6.9%	np	1.00%
2016/17	Average Fee Charged	\$1,866.38	\$1,936.09	\$2,342.64	\$1,552.28	\$2,278.47	\$2,223.31
	Standard Deviation	\$1,585.05	\$1,511.58	\$1,879.25	\$1,215.78	\$1,567.79	\$531.43
	Median	\$1,163.45	\$1,431.80	\$1,211.35	\$1,181.45	\$1,490.60	\$2,107.90
	25th Percentile	\$849.55	\$1,045.40	\$1,148.25	\$1,162.20	\$1,412.95	\$2,102.00
	95th Percentile	\$5,050.00	\$5,597.75	\$6,000.00	\$4,892.00	\$4,900.00	\$3,550.00
	Bulk Billed Rate	7.8%	2.90%	8.70%	16.5%	4.0%	1.60%

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

NP = not printed

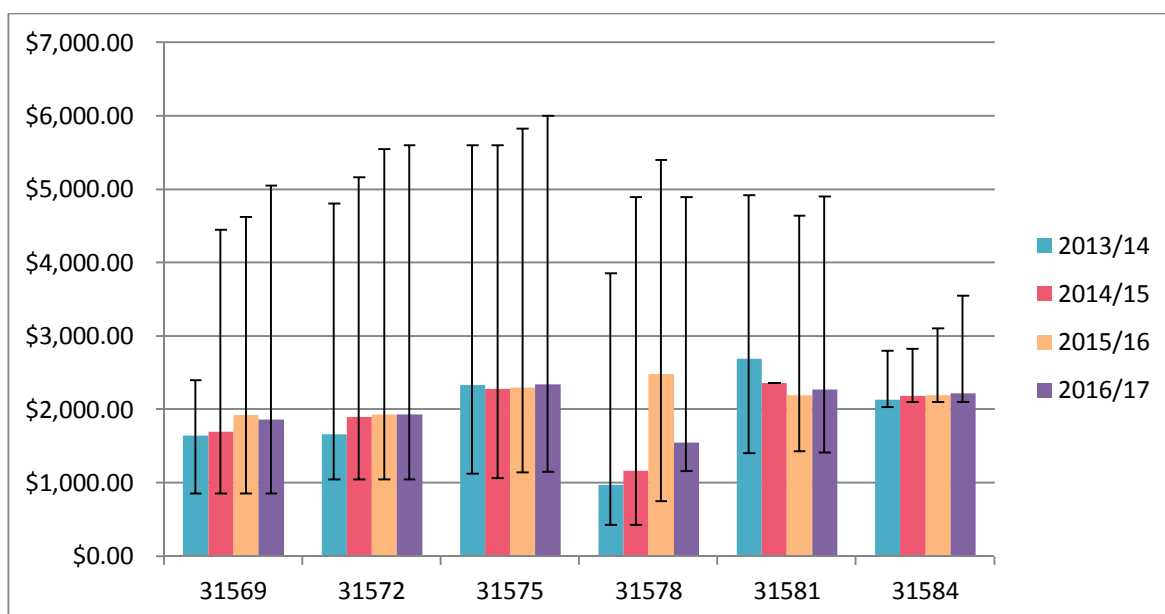


Figure 1: Average fee charged and the variation in fees charged from the 25th to the 95th percentiles for primary bariatric surgery items between 2013-14 and 2016-17.

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Patient breakdown

There were 48,097 patients who claimed bariatric services in 2016-17. 21,411 of these patients received a primary bariatric surgical service (31569-31584). This discrepancy in patient numbers is due to patients claiming multiple ongoing adjustment items (item 31587) after receiving gastric banding surgery.

Figures 2-5 represent patient demographics of those claiming bariatric items 31572, 31575, 31584 and 31587. These four items represent over 96% of total bariatric services rendered from 2013-14 to 2016-17.

The most common primary bariatric procedure, the sleeve gastrectomy (31575), is claimed predominantly by females aged 35-54. The most common of all the items, adjustment of a gastric band (31587), is claimed predominantly by females aged 45-54.

Table 11: Number of patients who received MBS listed bariatric services (31569-31590) from 2013-14 to 2016-17

Financial Year	Item no.								
	31569	31572	31575	31578	31581	31584	31587	31590	Total
2013-14	4,082	877	9,169	55	26	3,450	33,322	666	51,647
2014-15	2,819	1,315	11,311	39	24	3,525	30,164	638	49,835
2015-16	2,169	2,026	13,591	58	59	3,508	27,517	472	49,400
2016-17	1,504	2,422	15,950	122	101	3,635	23,974	389	48,097
Total	10,574	6,640	50,021	274	210	14,118	114,977	2,165	198,979

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Patient Demographics

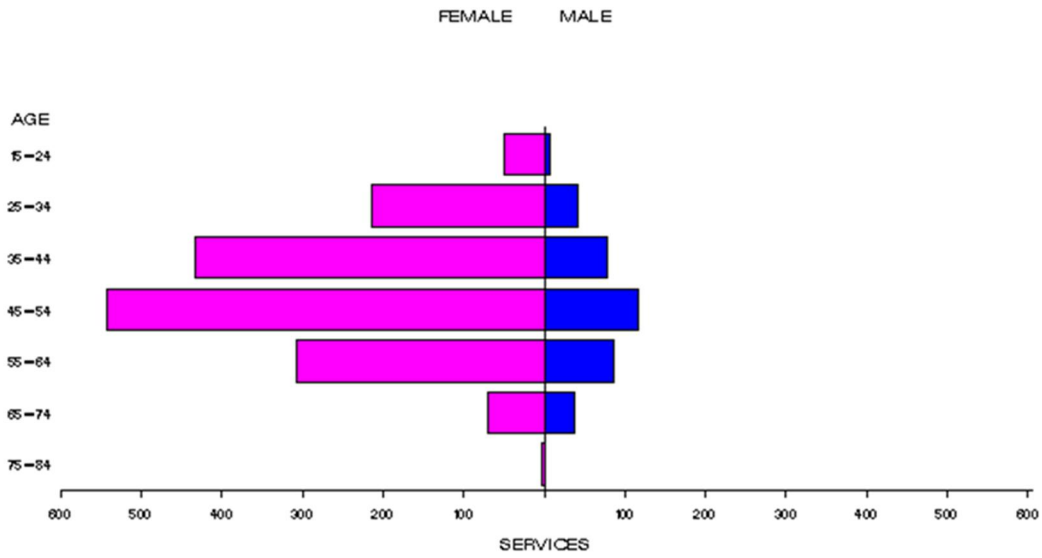


Figure 2: Demographic profile for MBS item 31572 processed from July 2015 to June 2016
 Source: Medicare Statistics Online

Patient Demographics

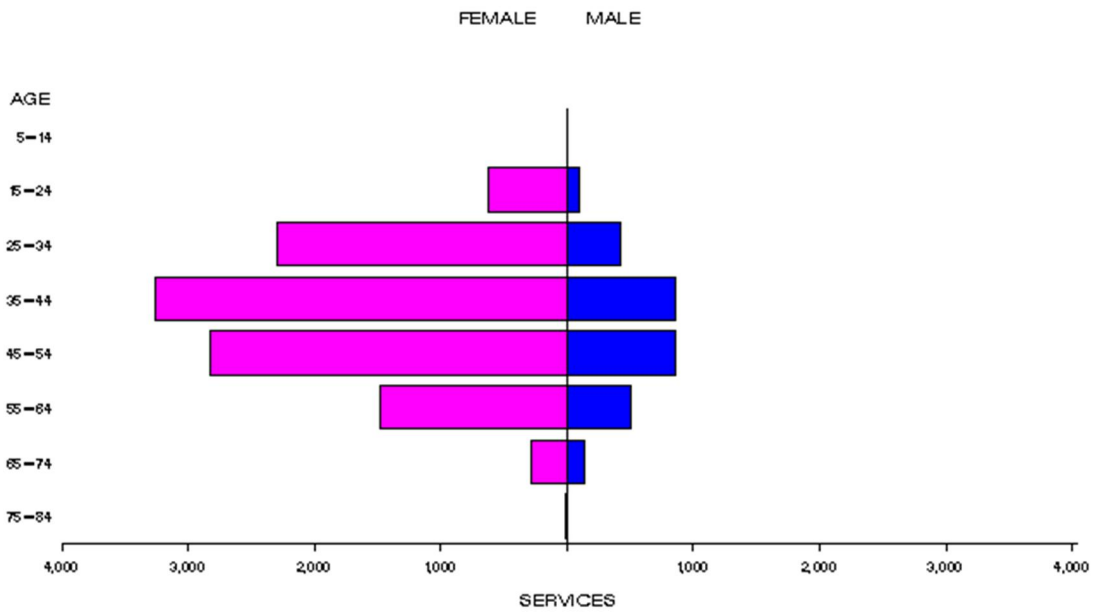


Figure 3: Demographic profile for MBS item 31575 processed from July 2015 to June 2016
 Source: Medicare Statistics Online

Patient Demographics

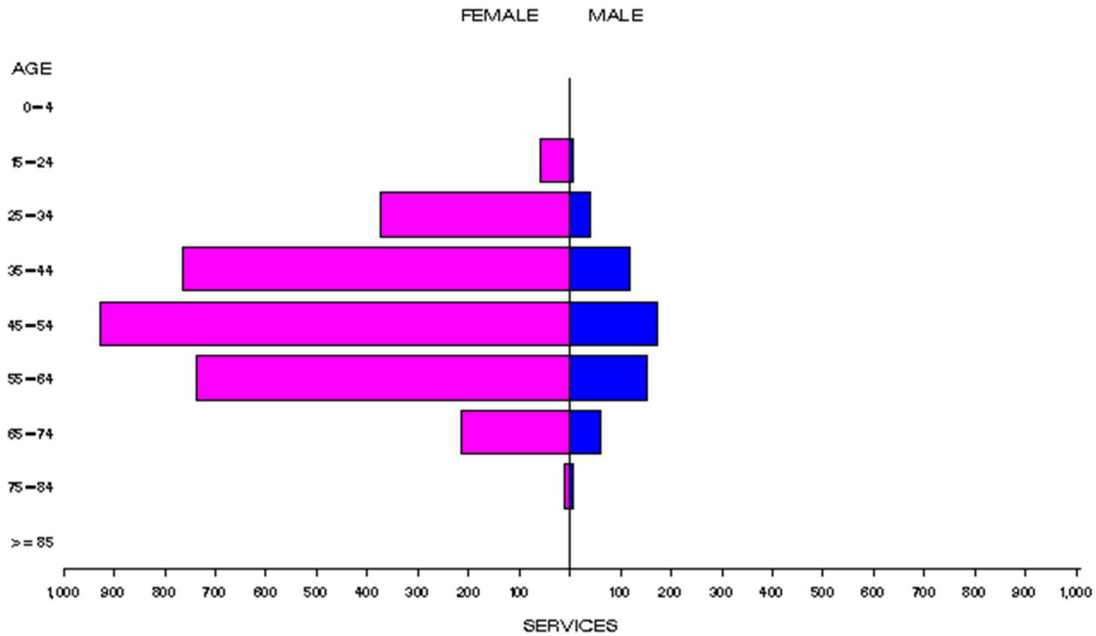


Figure 4: Demographic profile for MBS item 31584 processed from July 2015 to June 2016

Source: Medicare Statistics Online

Patient Demographics

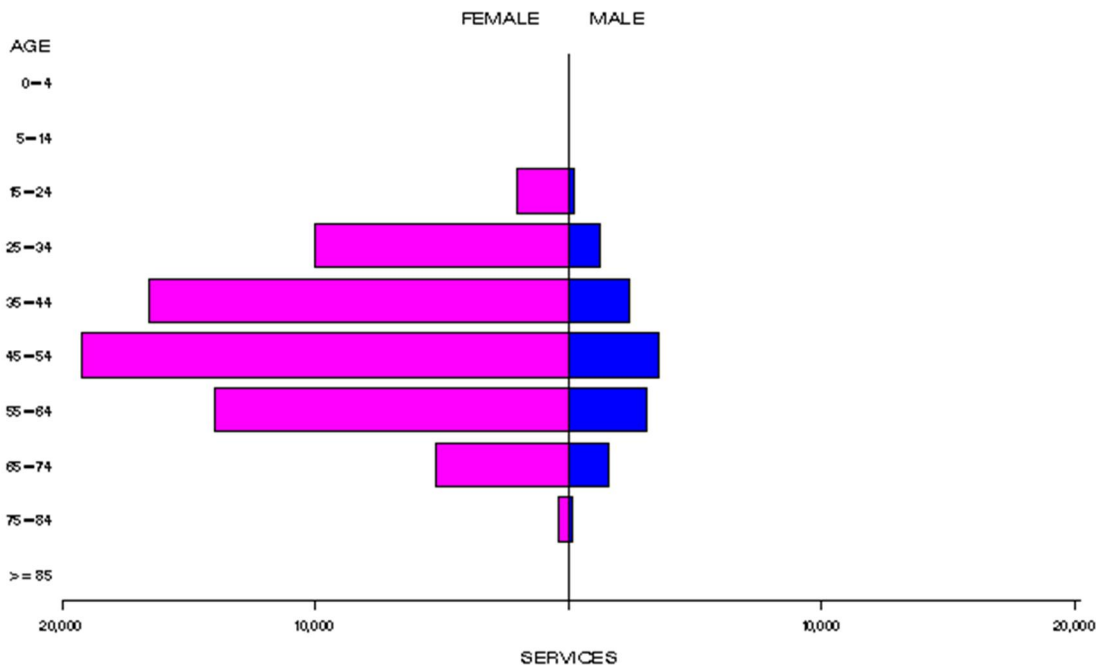


Figure 5: Demographic profile for MBS item 31587 processed from July 2015 to June 2016

Source: Medicare Statistics Online

Provider breakdown

Across the four years from implementation to present it is apparent that as service volumes increased so too did the number of providers for each procedure type (Tables 12-17). The decrease in gastric banding (31569) over the last four years has resulted in a decrease in the number of providers performing this surgery, with bariatric surgeons performing only 15.9 gastric banding procedures on average per year, compared with surgeons performing 163.7 sleeve gastrectomy (31575) procedures on average per year.

Of the six primary surgical bariatric items, 310 practitioners provided these services in 2016-17. 226 providers claimed item 31575 (sleeve gastrectomy) in 2016-17 and 10% of these

practitioners provided over 50% of the total services. 50% of these 226 practitioners provided over 94% of the total services rendered under item 31575 in 2016-17 (Table 18).

Table 12: Number of practitioners providing services under item 31569 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	144	4,097	28.5
2014-15	137	2,830	20.7
2015-16	123	2,181	17.7
2016-17	95	1,512	15.9
All Years	206	10,620	51.6

Table 13: Number of practitioners providing services under item 31572 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	81	882	10.9
2014-15	99	1,323	13.4
2015-16	97	2,029	20.9
2016-17	129	2,424	18.8
All Years	155	6,658	43.0

Table 14: Number of practitioners providing services under item 31575 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	164	9,177	56.0
2014-15	174	11,326	65.1
2015-16	207	13,617	65.8
2016-17	226	15,980	70.7
All Years	306	50,100	163.7

Table 15: Number of practitioners providing services under item 31578 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	17	55	3.2
2014-15	14	39	2.8
2015-16	16	58	3.6
2016-17	21	127	6.0
All Years	46	279	6.1

Table 16: Number of practitioners providing services under item 31581 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	12	26	2.2
2014-15	8	24	3.0
2015-16	10	59	5.9
2016-17	17	101	5.9
All Years	30	210	7.0

Table 17: Number of practitioners providing services under item 31584 from 2013-14 to 2016-17

Fin Year	Providers	Services	Average
2013-14	213	3,525	16.5
2014-15	228	3,612	15.8
2015-16	224	3,592	16.0
2016-17	248	3,689	14.9
All Years	341	14,418	42.3

Source (tables 12-17): Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Note: Providers will have rendered services in more than one financial year, therefore provider counts for the combined period will be less than the sum of provider counts for each financial year

Table 18: Cumulative percentage of medical practitioners providing item 31575 and number of services accounted for at each percentile, 2013-14 to 2016-17

Provider cumulative	2013-14	2014-15	2015-16	2016-17	All Years
1	6.1	5.5	9.8	14.1	11.8
5	23.2	23.3	29.9	34.6	37.2
10	40.0	38.7	45.7	50.2	56.3
20	62.2	61.6	66.7	69.8	79.8
25	70.2	70.5	74.3	76.6	86.5
30	77.3	77.4	80.3	81.7	91.4
40	87.1	87.0	89.5	89.2	96.9
50	93.5	92.9	94.8	94.4	99.0
60	97.2	96.7	97.6	97.5	99.7
70	99.0	98.7	99.2	99.0	99.8
75	99.5	99.3	99.5	99.4	99.8
80	99.6	99.6	99.7	99.7	99.9
90	99.8	99.8	99.8	99.9	99.9
95	99.9	99.9	99.9	99.9	100.0
99	100.0	100.0	100.0	100.0	100.0

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Co-claiming

The following co-claiming data represents the top 10 instances of co-claiming for items 31569, 31572, 31575 and 31584 in 2016-17. These items represent over 99% of total in-hospital bariatric procedures performed during this financial year.

In approximately 30%-47% of episodes, the four items depicted in Tables 19-22 were claimed alone. The remaining 53%-70% of episodes across these four items were co-claimed with another item. The most popular co-claimed items are subsequent consultation item 105, and item 30393 (LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes).

As of 1 November 2017, medical practitioners are no longer be able to claim MBS benefits for subsequent attendance items 105, 116, and 119 if they are claiming any Group T8 items with a schedule fee of equal to or greater than \$300 on the same day. Three new consultation items have been implemented (111, 117 and 120). These do not replace any current MBS items. They are additional items to be used in extenuating circumstances whereby a consultation takes place and is followed by a T8 surgical procedure on the same day, with a schedule fee \$300 or more.

The procedure must be unscheduled and otherwise unpredicted prior to the consultation. Future MBS data should not portray any co-claiming of subsequent consultation items with a primary bariatric procedure. Medical practitioners who are not claiming subsequent attendance items with Group T8 items will not be affected.

Table 19: Top 10 instances of co-claiming with MBS item 31569 in 2016-17

#	Items	Episodes	Services	Schedule Fee for combination	Number of providers	Number of patients	% of episodes
1	31569	711	711	\$604,030	65	710	47.02%
2	31569 , 105	164	328	\$146,378	19	164	10.85%
3	31569 , 104	120	240	\$112,212	2	120	7.94%
4	31569 , 31584	89	178	\$174,787	13	88	5.89%
5	31569 , 30393, 31584	68	204	\$144,085	16	68	4.50%
6	31569 , 30393	32	64	\$35,565	18	32	2.12%
7	31569 , 104, 30393	30	90	\$35,909	3	30	1.98%
8	31569 , 105, 31468.	30	90	\$57,110	2	30	1.98%
9	31569 , 30473	29	58	\$27,205	3	29	1.92%
10	31569 , 51303	28	56	\$28,545	11	28	1.85%

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 20: Top 10 instances of co-claiming with MBS item 31572 in 2016-17

#	Items	Episodes	Services	Schedule Fee for combination	Number of providers	Number of patients	% of episodes
1	31572	852	852	\$890,681	73	852	35.16%
2	31572 , 30393	327	654	\$427,471	57	327	13.50%
3	31572 , 30393, 31584	232	696	\$508,718	27	232	9.57%
4	31572 , 30473	123	246	\$139,564	16	123	5.08%
5	31572 , 105	72	144	\$78,365	17	72	2.97%
6	31572 , 31584	57	114	\$117,523	15	57	2.35%
7	31572 , 105, 30393	50	150	\$67,513	21	50	2.06%
8	31572 , 31468	37	74	\$72,466	15	37	1.53%
9	31572 , 105, 30473	36	108	\$42,370	3	36	1.49%
10	31572 , 30393, 30473	36	108	\$48,656	13	36	1.49%

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 21: Top 10 instances of co-claiming with MBS item 31575 in 2016-17

#	Items	Episodes	Services	Schedule Fee for combination	Number of providers	Number of patients	% of episodes
1	31575	7,040	7,040	\$5,980,407	164	7,031	44.06%
2	31575 , 105	2,859	5,720	\$2,551,886	62	2,856	17.89%
3	31575 , 51303	875	1,750	\$892,185	52	875	5.48%
4	31575 , 30393	797	1,594	\$885,786	91	794	4.99%
5	31575 , 31468	441	882	\$820,971	48	441	2.76%
6	31575 , 105, 30393	434	1,302	\$501,271	39	434	2.72%
7	31575 , 30390	322	644	\$308,975	13	320	2.02%
8	31575 , 104	302	604	\$282,400	8	301	1.89%
9	31575 , 30473	280	560	\$262,757	25	280	1.75%
10	31575 , 30391	188	376	\$186,449	8	188	1.18%

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

Table 22: Top 10 instances of co-claiming with MBS item 31584 in 2016-17

#	Items	Episodes	Services	Schedule Fee for combination	Number of providers	Number of patients	% of episodes
1	31584	1,083	1,083	\$1,666,845	124	1,078	29.36%
2	31584 , 30393	426	852	\$767,728	87	426	11.55%
3	31584 , 105	253	508	\$400,357	39	253	6.86%
4	31584 , 30393, 31572	232	696	\$508,718	27	232	6.29%
5	31584 , 105, 30393	165	496	\$304,295	45	164	4.47%
6	31584 , 104, 30393	114	342	\$215,323	14	114	3.09%
7	31584 , 31569	89	178	\$174,787	13	88	2.41%
8	31584 , 31575	78	156	\$153,184	14	78	2.11%
9	31584 , 104	75	150	\$121,849	18	75	2.03%
10	31584 , 30939, 31569	68	204	\$144,085	16	68	1.84%

Source: Department of Health, Medical Benefits Division, Primary Care and Diagnostics Branch, MBS Analytics Section, Reference no.: Q20863, July 2017

6. Background

In mid-2010 the Department contracted Deloitte Access Economics to conduct a review of MBS bariatric services and their findings were presented to MSAC under application 1180r at the 54th MSAC meeting from 29-30 November 2011. Based on the findings of the report, MSAC recommended that the services be retained but the items restructured to eliminate ambiguity and co-claiming issues. It was recommended the term ‘morbid obesity’ be changed to ‘clinically severe obesity’, and that a registry be created to collect long term data to improve quality and safety of bariatric surgery in Australia.

On 1 July 2013, after extensive stakeholder consultation, including the Department working closely with the Obesity Surgical Society of Australia and New Zealand to agree on the best way forward, eight new and amended MBS items for bariatric surgery were implemented (31569-31590). The Commonwealth Government also commenced funding of the Bariatric Surgery Registry from May 2014.

At the MSAC Executive’s 27 July 2017 meeting, the Department noted a range of issues around bariatric surgery, including patient access and high out of pocket costs. The MSAC Executive

agreed that a PvA review of these items is warranted and the Department agreed to undertake this as soon as possible.

7. Item Descriptors

31569 Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)

Fee: \$849.55 **Benefit:** 75% = \$637.20

31572 Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a services to which item 30515 applies (Anaes.) (Assist.)

Fee: \$1,045.40 **Benefit:** 75% = \$784.05

31575 Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)

Fee: \$849.55 **Benefit:** 75% = \$637.20

31578 Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)

Fee: \$849.55 **Benefit:** 75% = \$637.20

31581 Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)

Fee: \$1,045.40 **Benefit:** 75% = \$784.05

31584 Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Anaes.) (Assist.)

Fee: \$1,539.10 **Benefit:** 75% = \$1,154.35

31587 Adjustment of a gastric band as an independent procedure including any associated consultation

Fee: \$97.95 **Benefit:** 75% = \$73.50 85% = \$83.30

31590 Adjustable gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)

Fee: \$251.70 **Benefit:** 75% = \$188.80 85% = \$213.95

8. Further information on MSAC

MSAC Terms of Reference and other information are available on the MSAC Website at:

www.msac.gov.au.