# Summary of MBS changes for Interventional Cardiology (Angiography, PCI and related procedures) due for introduction on 1st July 2021.

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**Executive Summary**

The new item descriptors for coronary angiography and PCI will be introduced on July 1, 2021. These descriptors are based on the MBS Task Force report of August, 2018. CSANZ has previously expressed concerns about unforeseen consequences for health care providers and barriers for patients. The message delivered by CSANZ was that the craft group was not opposed to change but that such change needed to reflect current and best practice. A key concern for CSANZ was to avoid unintentional denial of therapy.

The first major change for Interventional Cardiology was that inclusion criteria now apply. Broadly speaking, the indications are broken into 2 groups (see section 4): a high risk group (Acute Coronary Syndromes or equivalent), where functional testing is generally not indicated, and a clinically stable group, where functional testing generally is indicated. CT coronary angiography is split across those groups, with prognostic disease (Left main and proximal LAD) being included in the high-risk group. The indications are mirrored across angiography and PCI such that if the person is eligible for an angiogram, then if suitable anatomy is found, they are also suitable for PCI. Importantly, "Heart Team" meetings can now be used as a "Failsafe" to allow angiography and PCI when the usual indications do not apply.

The second major change is that for most procedures, a single descriptor will cover the entire procedure. This will improve consistency in how providers claim benefits but did produce challenges in terms of cost neutrality. CSANZ was vigilant in attempting to achieve cost neutrality and this was particularly difficult in PCI.

The third major change is that PCI moves to a per vascular territory model rather than a per occlusion site model. A vascular territory is defined as the territory of a major artery (eg LAD) and all of its branches. Separate rules apply for left main, intermediate artery and bypass grafts, as detailed in this report.

Despite these challenges, during a long but collegial process, CSANZ has been successful in achieving many modifications to the original descriptors such that the majority of CSANZ concerns have been resolved. CSANZ is now comfortable that the new item descriptors should not cause any significant issues when implemented.

**1. Introduction**

The Final Report from the Cardiac Services Clinical Committee (as part of the Medicare Benefits Schedule Review Taskforce) was released on 2nd August 2018 and subsequently endorsed by the Minister. The rationale for these changes, as stated, was to:

- amend item descriptors to reflect current practice.
- combine similar surgical procedures.
- introduce items that represent a complete medical service.
- incentivise advanced techniques.
- remove procedures that no longer represent best practice.
- reduce low value invasive angiography and align coronary artery stenting with current best practice.

From the Cardiologist's perspective, the 3 major issues (with regards interventional cardiology) are the move to inclusion criteria, cost neutrality of moving to a single item descriptor for a complete service and PCI moving to a per territory model. These issues are discussed in detail in this document.

These new descriptors will be introduced into the MBS as of July 1, 2021. CSANZ co-authored a document summarising these changes in March, 2021. Since then, there have been significant changes to the format (but not intent) of the item descriptors as a consequence of editing by legal writers from the Attorney General's Department.

Note that in the new format, the indications for a procedure will be listed elsewhere in the MBS schedule and the item descriptor will refer to that indication clause with a link. This results in simplification of the descriptor but does require the user to navigate from one site in the MBS schedule to another and, on balance, CSANZ was not in favour of this change.

Feedback from the document released in March has included concerns relating to intra-coronary imaging (OCT/IVUS). Note that this MBS review was centred on existing item descriptors and the Task Force did not recommend any new descriptors. Intra-coronary imaging will thus need to proceed through MSAC, a process which CSANZ believes is in progress.

The changes are complex, and the following document is a summary and explanation of the new item descriptors.

**2. Background and Implementation Liaison Group (ILG)**

The Tasks Force's initial proposed changes to angiography and PCI have previously been released, as have CSANZ's concerns documenting unforeseen consequences for health care providers and barriers for patients.

The message delivered by CSANZ was that the craft group was not opposed to appropriate use criteria but that such criteria needed to reflect current and best practice. An additional key concern for CSANZ was to avoid unintentional denial of therapy.

After the release of the final report of the MBS Taskforce, the Department of Health established the Implementation Liaison Group (ILG) to "work with key stakeholders and relevant clinical experts in finalising the item descriptors, endeavouring to mitigate any unforeseen consequences for stakeholders or barriers for patients." The ILG consisted of many stakeholders, including CSANZ, private hospitals, insurers, RACGP, AMA and patient advocates.

Separately to CSANZ, an independent group of Cardiologists had been lobbying Government for additional changes to the Task Force's initial proposals. Two members of that group (Roger Allan and Mark Pitney) were invited by Govt to become part of the Implementation Liaison Group. The collaboration between CSANZ, represented by Michael Feneley, and this independent group and the ability of the Department of Health to be receptive and responsive need to be acknowledged as the key to solving the difficult and complex implementation issues.

The cornerstone of the CSANZ concerns was avoidance of unintentional denial of therapy. Given that position, it was argued strongly that there needed to be a mechanism to perform angiography or intervention if there was a strong clinical need, even if the patient did not "fit" the specified inclusion criteria. The agreed solution was to use "Heart Teams" as a failsafe. CSANZ also strongly argued that Cardiologists needed to be able to treat people based on symptom relief rather than pure prognostic benefit.

Finally, as previously noted by CSANZ, amalgamation of item numbers into a single service item number, although being laudable, was never going to be simple to introduce. The Department had already given an undertaking of cost neutrality to the provider, and CSANZ did a significant amount of work with the Department to achieve this goal.

**3. Item Number Structure**

The Task Force's goal was for a simplified approach of 1 item descriptor that covered the whole procedure. It was recognised that "highest risk" patients would have different indications for angiography and thresholds for revascularisation than "lower risk" patients and hence, these groups were split (see next section).

Broadly, the highest risk group (subsequently referred to as ACS/High Risk Group in this document) was meant to represent patients at risk of short-term harm who generally would not be subjected to testing for inducible ischaemia but rather considered for early revascularisation. This group consists of ACS (STEMI, NSTEMI, post arrest, shock etc) and unstable angina with high-risk clinical features (see eligibility clause in next section). Left main and proximal LAD disease detected on CT coronary angiography were also added to this group as the treatment principles are similar (functional testing is generally not performed and early revascularisation is considered optimal).

The alternative group (subsequently referred to as the Clinically Stable Group) consisted of patients where functional testing for demonstratable ischaemia is usually performed and where a trial of medical therapy and delayed revascularisation is often appropriate.

The "simplification goal" was made more difficult by the additional requirement to differentiate between grafts or no grafts, *ad hoc* vs staged PCI and single or multi-territory disease. To avoid adding further variables, graft angiography was made indifferent to the presence or absence of an

IMA graft (given that it exists in the majority, >90% of cases). Similarly, the angiography item descriptors are indifferent to left heart catheterisation, LV gram or aortogram.

***A simplified item descriptor list which highlights the item number structure is shown below. CSANZ suggests that members may wish to print this page as a guide:***

***High Risk Group***
38244: Angiography alone, no grafts ($920.00)
38247: Angiography alone with grafts ($1473.95)
38307: Angiography proceeding to single territory PCI ($1844.60)
38308: Angiography proceeding to double territory vessel PCI ($2122.25)
38310: Angiography proceeding to triple territory PCI ($2399.90)
38316: Stand-alone single territory PCI ($1648.95)
38317: Stand-alone double territory PCI ($2088.80)
38319: Stand-alone triple territory PCI ($2366.45)

***Clinically Stable Group***
38248: Angiography alone, no graft ($920.00)
38249: Angiography alone with grafts ($1473.95)
38311: Angiography proceeding to single territory PCI ($1844.60)
38313: Angiography proceeding to double territory PCI ($2122.25)
38314: Angiography proceeding to triple territory PCI ($2399.90)
38320: Stand-alone single territory PCI ($1648.95)
38322: Stand-alone double territory PCI ($2088.80)
38323: Stand-alone triple territory PCI ($2366.45)

***Non IHD group***
38251: Angiography for valve disease, no grafts ($920.00)
38252: Angiography for valve disease, with grafts ($1473.95)

***Additional add on items***
38254: Right heart catheter during angiography ($463.50 @ 50% ie $231.75 by multiple item rule.)
38309: Rotablation ($1250.70) @ 50% ie $625.35, irrespective of number of vessels treated.
38241: FFR/iFR or equivalent ($484.35, claimable per vessel with multiple procedure rule, ie fee for a single vessel is $242.20, if performed in 2 vessels $363.25 , 3 vessels $484.35 )
38362: Intra-aortic balloon pump ($396.00) *may be standalone

***Additional stand-alone (cannot be co claimed with any of above)***
38200: Right heart catheter without angiography ($459.35)
38203: Left heart catheterisation without angiography ($548.15)
38206: Left and right heart catheterisation without angiography ($662.75)

**4. Eligibility Clauses**

The format for the item descriptors has changed and now each item descriptor references an eligibility clause. CSANZ recognises that this language is not simple and did not support the changes in item descriptors, but the following will be as it appears in the schedule.

(a) 5.10.17A is the eligibility clause which relates to <u>all item descriptors in the "ACS/High Risk Group"</u>

**5.10.17A Items 38244, 38247, 38307, 38308, 38310, 38316, 38317 and 38319—patient eligibility and timing**

(1) A patient is eligible for a service to which item 38244, 38247, 38307, 38308, 38310, 38316, 38317 or 38319 applies if:
- (a) subclause (2) applies to the patient; and
- (b) a service to which the item applies has not been provided to the patient in the previous 3 months, unless:
  - (i) the patient experiences a new acute coronary syndrome or angina, as described in paragraph (2)(a), (b) or (c), in that period; or
  - (ii) for a service to which item 38316, 38317 or 38319 applies—the service was provided to the patient in that period as a subsequent stage following an initial primary percutaneous coronary intervention procedure.

(2) This subclause applies to a patient who has:
- (a) an acute coronary syndrome evidenced by any of the following:
  - (i) ST segment elevation;
  - (ii) new left bundle branch block;
  - (iii) troponin elevation above the local upper reference limit;
  - (iv) new resting wall motion abnormality or perfusion defect;
  - (v) cardiogenic shock;
  - (vi) resuscitated cardiac arrest;
  - (vii) ventricular fibrillation;
  - (viii) sustained ventricular tachycardia; or
- (b) unstable angina or angina equivalent with a crescendo pattern, rest pain or other high-risk clinical features, such as hypotension, dizziness, pallor, diaphoresis or syncope occurring at a low threshold; or
- (c) either of the following, detected on computed tomography coronary angiography:
  - (i) significant left main coronary artery disease with greater than 50% stenosis or a cross-sectional area of less than 6 $mm^2$;
  - (ii) severe proximal left anterior descending coronary artery disease (with stenosis of more than 70% or a cross-sectional area of less than 4 $mm^2$ before the first major diagonal branch).

(b) 5.10.17B is the eligibility clause that relates to <u>angiography alone in stable syndromes</u>

**5.10.17B Items 38248 and 38249—patient eligibility**

(1) A patient is eligible for a service to which item 38248 or 38249 applies if:
- (a) subclause (2) applies to the patient; or
- (b) the patient is recommended for coronary angiography as a result of a heart team conference that meets the requirements of subclause (3).

(2) This subclause applies to a patient who has:
- (a) limiting angina or angina equivalent, despite an adequate trial of optimal medical therapy; or
- (b) high risk features, including at least one of the following:
  - (i) myocardial ischaemia demonstrated on functional imaging;
  - (ii) ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing;

(iii) computed tomography coronary angiography evidence of one or more coronary arteries with stenosis of 70% or more; or
(iv) left ventricular dysfunction with an ejection fraction of less than 40% or segmental wall motion abnormality at rest.

(3) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:
(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
(i) an interventional cardiologist;
(ii) a non-interventional cardiologist;
(iii) a specialist or consultant physician; and
(b) the team must:
(i) assess the patient's risk and technical suitability to receive the service; and
(ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and
(c) a record of the conference must be created, and must include the following:
(i) the particulars of the assessment of the patient during the conference;
(ii) the recommendations made as a result of the conference;
(iii) the names of the members of the team making the recommendations.

(c) 5.10.17C is the clause that relates to <u>PCI and angiography proceeding to PCI in stable syndromes</u>

**5.10.17C Items 38311, 38313, 38314, 38320, 38322 and 38323—patient eligibility**

(1)A patient is eligible for a service to which item 38311, 38313, 38314, 38320, 38322 or 38323 applies if:
(a) subclause (2) applies to the patient; or
(b) the patient is recommended for the service as a result of a heart team conference that meets the requirements of subclause (4).

(2) This subclause applies to a patient if:
(a) the patient has any of the following:
(i) limiting angina or angina equivalent despite an adequate trial of optimal medical therapy;
(ii) myocardial ischaemia demonstrated on functional imaging;
(iii) high risk features such as ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing; and
(b) the patient has either of the following in a vascular territory treated:
(i) a stenosis of 70% or more;
(ii) a fractional flow reserve of 0.80 or less, or non-hyperaemic pressure ratios distal to the lesions of 0.89 or less; and
(c) for items 38314 and 38323—either:
(i) the patient does not have diabetes mellitus and the multi-vessel coronary artery disease of the patient meets the criterion in subclause (3); or
(ii) despite a recommendation that surgery is preferable, the patient has expressed a preference for catheter-based intervention.

(3) For the purposes of subparagraph (2)(c)(i), the criterion for the multi-vessel coronary artery disease is that the disease does not involve any of the following:
(a) stenosis of more than 50% in the left main coronary artery;
(b) bifurcation lesions involving side branches with a diameter of more than 2.75 mm;
(c) chronic vessel occlusions for more than 3 months;
(d) severely angulated or calcified lesions;
(e) a SYNTAX score of more than 23.

(4) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:
(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
(i) an interventional cardiologist;
(ii) a specialist or consultant physician;
(iii) for items 38314 and 38323—a cardiothoracic surgeon;

(iv) for items 38311, 38313, 38320 and 38322—a cardiothoracic surgeon or a non-interventional cardiologist; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

**5. Reimbursement Modelling**

Review of Medicare data showed that Interventional procedures were billed in a variety of ways with a variety of costs and thus the rationale for standardisation was sound. The Task Force recommendation was for an amalgamation of item numbers into a single service item description (where possible). It was hoped that this could also simplify billing but, as previously mentioned, the multifactorial aspects (ACS/High Risk Group vs Clinically Stable Group, grafts vs non grafts, *ad hoc* vs elective, single vs double vs triple vessels) resulted in a large number of unique item descriptors.

The Department and Task Force also agreed to cost neutrality, and significant modelling was performed by the Cardiologists participating in the ILG to try to achieve this. The greatest challenge was in PCI. CSANZ's firm position was that any risk of cost non-neutrality needed to be borne by the MBS given that it was the Task Force that recommended a change in the fee structure. To help calculate the effect of moving from a per lesion to per territory model, data from a Sydney Teaching hospital and related Metropolitan hospital was analysed over a 5 year period, and the average figure of 1.4 to 1.6 treated segments per vascular territory was demonstrated. The figure of 1.4 was applied to the current stent descriptor (38306 rebate X 1.4 is approx. $1100) with subsequent complex adjustment for the multiple items rule.

It is important to note that this was designed as an exercise in cost neutrality. It is accepted that there is an argument that complexity is not reflected in the current fee structure. The Task Force did not recommend any changes to that and cost adjustment was beyond the scope of the ILG.
The Task Force also noted Medicare data showing a significant number of operators were charging again for repeat diagnostic angiography at the time of elective or staged PCI, and the Task Force recommended that this be blocked. CSANZ accepted this position. As such, the new item descriptors define elective PCI as PCI within 3 months of diagnostic angiography and concurrent angiography cannot be claimed with these procedures (see also sections 8 & 9).

In modelling, the current situation needed to be defined as a baseline and using the most frequent grouping of item descriptors, the current situation, with proposed new fees is shown:

(i) Coronary angiography without grafts:
Calculated from 59925 + 38218 (assumes LV pressure measured)
Current fee $916.75, proposed fee $920.00 (indifferent of LV pressure measurement)

(ii) Coronary angiography with grafts:
Calculated from 59925 + 38240 (assumes LIMA + SVG)

Current fee $1465.75, proposed fee $1473.95 (now indifferent to number or type of grafts)

(iii) Coronary angiography (no grafts) proceeding to PCI :
Calculated from 59925 + 38246 + 38306 @ 50% (1st stent)
Adjusted to allow for per territory vs per segment.
Current fee $1675.87 (single stent), proposed fee $1844.60 (single territory), $2122.25 (double territory) and $2399.90 (triple territory)

(iv) Standalone PCI:
Calculated from 59912 + 38306 (1st stent) + 38243 @ 50%
Adjusted to allow for per territory vs per segment.
Current fee $1324.67 (single stent), proposed fee $1648.95 (single territory), $2088.80 (double territory) and $2366.45 (triple territory)

(v) Rotational atherectomy
Currently there are 4 item descriptors for Rotational atherectomy covering stents vs no stent and single vs multiple arteries. Additionally, the multiple items rule has a variable effect depending on presence or absence of angiography. The Task Force recommended simplification, with 1 item descriptor that could be charged in addition to the PCI descriptor. After negotiation, that fee was set as the weighted (by current usage) average of the four existing item numbers. The multiple items rule will always apply with this descriptor so the true fee should be considered as 50% of the shown fee. The descriptor has also been made indifferent to stents vs balloon angioplasty, in keeping with the changes made to the other PCI descriptors.

(vi) PCI without stent
The current fee structure has different descriptors for PCI with stenting and PCI without stenting, with a lower fee for the latter. Given that the new model moves towards an all-encompassing item descriptor, this would have meant creating multiple additional descriptors for PCI without stenting in ACS vs non-ACS indication, *ad hoc* vs elective and single/double/triple territories (i.e., 12 additional descriptors). Additionally, review of data from the same Teaching Hospital/Metropolitan hospital showed that PCI procedures where a stent was not performed frequently involved the treatment of instent restenosis with drug eluting balloons (where lesion preparation time can be significant) or complex bifurcation disease. On average, procedure times for cases involving PCI without stenting were longer than PCI with stenting, and creating multiple new descriptors (with a plan for a reduced fee) seemed inappropriate to the ILG. As such, all the PCI descriptors are now indifferent to the presence or absence of stenting, noting that the lesion requirements for intervention remain the same (ie, a balloon angioplasty to a small branch vessel which does not fulfil PCI item descriptor requirements should not be claimed)

(vi) Pressure wire (FFR/iFR or equivalent non-hyperaemic pressure ratios)
The current descriptor limits the usage of this item to angiography only, ie, it currently cannot be claimed during PCI without angiography. As part of the ILG discussions, this has been modified to allow for FFR/iFR to be performed during standalone PCI. This descriptor is now to be applied per vessel (with adjustment for multiple items) and is not vendor-specific.

**6. Heart Team Meeting**

Heart Team meetings are used in the new descriptors in 2 ways. For angiography and non-triple vessel PCI, they are used as a "failsafe" back-up mechanism where a patient who does not fulfil requirements for intervention can still undergo intervention if a Heart Team Meeting agrees. This is a very important mechanism that should eliminate unintentional denial of therapy. For triple vessel PCI, Heart Teams are used to help define whether surgery or PCI is the optimal therapy.

With the exception of triple vessel disease, Heart Team requirements for angiography and PCI in stable syndromes are defined by eligibility clause 5.10.17B and require 3 doctors, 1 of which must be a non-interventional cardiologist.

(3)For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
  (i) an interventional cardiologist;
  (ii) a non-interventional cardiologist;
  (iii) a specialist or consultant physician; and

(b) the team must:
  (i) assess the patient's risk and technical suitability to receive the service; and
  (ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and

(c) a record of the conference must be created, and must include the following:
  (i) the particulars of the assessment of the patient during the conference;
  (ii) the recommendations made as a result of the conference;
  (iii) the names of the members of the team making the recommendations.

For triple vessel disease (non ACS), the intent is to offer the patient the best therapy, acknowledging that the data may evolve and rather than establishing "rules" it was better to define complexity and mandate that complex patients be discussed. Membership of the Heart Team is defined by the eligibility clause 5.10.17C and must include a cardiothoracic surgeon.

(4)For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
  (i) an interventional cardiologist;
  (ii) a specialist or consultant physician;
  (iii) for items 38314 and 38323—a cardiothoracic surgeon;
  (iv) for items 38311, 38313, 38320 and 38322—a cardiothoracic surgeon or a non-interventional cardiologist; and

(b) the team must:
  (i) assess the patient's risk and technical suitability to receive the service; and
  (ii) make a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(c) a record of the conference must be created, and must include the following:
  (i) the particulars of the assessment of the patient during the conference;
  (ii) the recommendations made as a result of the conference;
  (iii) the names of the members of the team making the recommendations.

**7. Item Descriptors: Angiography alone**

For stand-alone angiography, the Task Force recommended that 3 groups be created based on indication. As discussed in section 4, the ACS/High Risk Group represent patients at highest risk who generally would not be subjected to functional testing for inducible ischaemia but rather considered

for early revascularisation. By contrast, the Clinically Stable Group consists of patients where functional testing for demonstratable ischaemia is usually performed and where a trial of medical therapy and delayed revascularisation is often appropriate. Finally, a non IHD (valve) group exists. Fees are indifferent to the indication, so that amalgamation was technically possible, but the Task Force requested separation by indication, presumably to allow for ongoing data collection.

Additionally, the item descriptors are subdivided into items with grafts vs no grafts. To reduce the number of variables, the item descriptor is now indifferent to whether there is an IMA graft because most cases do have an IMA graft, and that the funding calculations were based on the presence of an IMA graft. Finally, the descriptor is now indifferent to whether left heart pressures are measured or whether an LV gram is performed (previously this was item 59925 vs 59912).

The Clinically Stable Group items cannot be repeated within 3 months under any circumstance, but the High Risk Group items can be repeated if a new ACS (as defined by descriptor) occurs. Angiography for valve patients cannot be repeated for 12 months, although if the patient were to develop an ACS, then that descriptor could be claimed. Angiography item descriptors allow for an anaesthetist to charge a MBS anaesthetic fee if they are present for the procedure. Angiography item descriptors do not permit an assistant to charge a MBS fee. The proposed new angiography item descriptors are shown in Appendix A.

**8. Item Descriptors: Angiography proceeding to PCI**

For angiography proceeding to PCI, the overarching ideal was that the indications for angiography were mirrored in the PCI descriptor, i.e., if the patient had an indication for the angiogram and a suitable lesion was shown, then PCI could be performed without having to reconsider the indication.

To charge these items, the patient must NOT have had an angiogram within the previous 3 months, unless a new ACS has occurred. This was specifically designed to block the practice of charging an additional angiogram during staged PCI, a practice considered unreasonable by the Task Force, CSANZ and the ILG. Angiography to "check" these previously treated vessels is considered a routine part of a staged PCI and reflected in the fee.

Staged procedures (if performed within 3 months) may use the *initial* indication, and are not required to requalify but subsequent procedures will be for "stand alone" PCI (no angiography). After 3 months, the procedure is no longer considered staged, and the patient must requalify with an appropriate indication and under those circumstances, repeat angiography may be claimable.

Single vs double vs triple refers to "vascular territories"; i.e., a major artery and all its branches is a single territory. As an example, PCI to the LAD and Diagonal is single territory disease whilst a PCI to LAD and Mg Cx is double territory disease. The following explanatory note will appear in the schedule to be used as guidance for left main, intermediate and grafts:

| Territory explanatory note:<br><br>For treatment of isolated Left Main Coronary Artery Disease (no involvement of the bifurcation), a single territory should be claimed, but if the treated segment involves the bifurcation, then 2 territories may be claimed. |
|---|

The intermediate artery when treated in isolation is a single territory, but when treated with the Left Anterior Descending or Circumflex artery, or both, may be claimed as a maximum of two territories.

Treatment of a single lesion in a bypass graft should be claimed as a single territory, regardless of how many vascular territories are supplied by that graft. If more than one lesion is treated in a single graft and those lesions are in separate portions of a sequential graft, subtending different territories, then one additional territory may be claimed (maximum claim of two territories per graft).

In triple vessel disease in the Clinically Stable Group, regardless of the number of territories being revascularized, if the disease is complex then a Heart Team meeting is required. The exception is a patient who expresses a preference for catheter-based intervention, even when objective assessment indicates surgery would be preferable. The definition of complex disease is shown in section 4(c) but includes any of the following:

(i) Diabetes
(ii) Left main stenosis >50%
(iii) Bifurcation lesions involving side branches with a diameter >2.75mm
(iv) Chronic vessel occlusions (>3 months)
(v) Severely angulated or severely calcified lesions
(vi) Syntax score > 23

Lesion severity is appropriately prescriptive for the Clinically Stable Group; the descriptor specifies that the lesion must be > 70% or FFR/iFR positive. For the High Risk Group, it is recognised that some unstable lesions may be hard to quantify and clinical judgement is required. Although not specified in the actual descriptor, an explanatory note will address that issue.

The item descriptors are indifferent to the use of stents vs balloon alone; see Section 5 (vi) for details.

The scenario of coronary angiography with grafts proceeding to PCI is not fully catered for by the new descriptors and can only be claimed under the same item descriptors as angiography without grafts. This does not maintain cost neutrality for this relatively rare situation. The Department have acknowledged this argument and are looking at options to potentially address this scenario. This would be subject to a Government decision. Due to the late discovery of this issue, this issue will not be resolved at the time of initial implementation, but the issue has been recognised.

These descriptors allow an anaesthetist and an assistant to claim a fee using appropriate item descriptors. The proposed new descriptors are shown in Appendix B.

**9. Item Descriptors: Elective / Staged PCI**

See also notes from the previous section as many of these apply to stand alone PCI.

These descriptors are applicable when angiography has been performed within the last 3 months and apply to elective and staged procedures. Staged PCI may be performed under the original indication if performed within 3 months. After 3 months, the patient would need to requalify for a PCI indication.

As above, single vs double vs triple refers to “vascular territories” not vessels. For patients with triple vessel disease in a non-ACS setting, regardless of the number of territories being revascularized,

complex disease (see definition in Section 8) requires a Heart Team meeting. The item number claimed should reflect the number of coronary vascular territories that are treated during the procedure, not the total number of territories treated to date. The item descriptor is indifferent to the use of stents vs balloon alone; see Section 5 (vi) for details.

The proposed new descriptors are shown in Appendix C.

**10. Additional add on items.**

The items following are expected to be added to either an angiography or PCI descriptor and are an exception to the 1 descriptor per procedure goal. The multiple procedure rule will apply, so their true fee will be reduced by at least 50% of the fee shown.

(i) FFR/iFR or equivalent
(ii) Rotational atherectomy
(iiI) Right heart catheter during angiography

Currently, FFR/iFR is only claimable during angiography and not PCI. That issue is resolved with these changes. At the Task Force's recommendation, FFR/iFR can now be charged per vessel, with the first vessel rebated at 50% of the shown fee and subsequent vessels at 25%, consistent with the multiple procedure rule. The use of iFR has also been made vendor neutral and is referred to as "use of a coronary pressure wire" and measurement of "non-hyperaemic pressure ratios" (see item number 38241 Appendix D)

Rotational atherectomy has been simplified from the current 4 descriptors to a single descriptor, regardless of the number of vessels or stents used: see section 5 (v) for further explanation.

The proposed new descriptors are shown in Appendix D.

**11. Additional stand-alone items (cannot be co claimed with any of above)**

These items have co-claiming restrictions and are expected to be claimed as a "stand-alone" descriptor with respect to other items shown above. The items are:

(i) Right heart catheter without angiography
(ii) Left heart catheter without angiography
(iii) Left and right heart catheter without angiography

The proposed new descriptors are shown in Appendix E.

**12. Clinical Scenarios that raise questions re the appropriate rebates claimed**

CSANZ is aware of several clinical scenarios that raise questions re appropriate rebate claims, and offers the following advice:

(a). Patient has a coronary angiogram performed by a non-interventionalist and refers to an interventionalist either at the same sitting or separate sitting for an FFR which is negative and does not lead to PCI.

CSANZ recommends that the interventionalist charges the FFR item descriptor. The interventionalist will not be able to charge a coronary angiography descriptor. Reimbursement will be $488.70 for the 1$^{st}$ territory and an additional 50% for a second territory, if required.

(b) Incomplete coronary angiography (unable to find a graft or a vessel and abandoned due to operator or patient fatigue, contrast loading etc) and then a second angiogram is performed by the original operator or a different operator.

CSANZ recommends that the item descriptor 30001 (operative procedure discontinued on medical grounds) be used for the initial procedure, which will reduce the reimbursement to 50% for the first procedure but allow for a second procedure to be claimed using the appropriate angiography descriptors.

(c) Rescue PCI whereby a patient with a failed procedure is transferred to another centre for a rescue procedure

CSANZ recommends the most appropriate solution is that the initial procedure should be claimed as a 30001 (50% of PCI fee) and the second procedure could then be claimed using the appropriate PCI descriptors.

(d) Angiography by one operator and PCI by another on same day

The Department has sought CSANZ's formal advice on this issue after CSANZ became aware of the Department's initial position suggesting that if practitioner A performs angiography and asks practitioner B to immediately follow on to PCI then practitioner B should charge the single 'angiography proceeding to PCI' rebate, that practitioner A should charge bill no item numbers but have a private arrangement with practitioner B to fee split. CSANZ has formally advised the Department that it *does not support* this model and has additional concerns about fee splitting, and has provided the Department with the following advice.

For acute /high-risk patients, it is best practice for the angiogram to be undertaken by a practitioner capable of immediately performing PCI. Consequently, the scenario described in the preceding paragraph should not arise in acute patients. It is acknowledged that there may be rare situations (eg rural and remote settings) where this best practice management cannot occur.

In patients considered to be clinically stable, to the extent that a practitioner who is not accredited to perform PCI does perform the coronary angiogram, CSANZ believes there is no urgency to proceed to PCI immediately, and it is preferable to pause after the angiogram to inform the patient of the findings, to consider whether continued medical therapy, PCI or surgery is the most appropriate treatment option *in consultation with the PCI-accredited cardiologist*, and to obtain the patient's informed consent if the decision is to proceed with PCI. Provided these steps can be completed on the same day as the angiogram, it is perfectly reasonable to perform PCI later on the same day, and this may be the most efficient scenario for the patient and the hospital if a PCI-accredited cardiologist is available. From a strictly medical standpoint, in a truly stable patient, it is also perfectly reasonable to discharge the patient and readmit to hospital at a later date for elective PCI.

If a PCI-accredited cardiologist (who knows the patient and clinical presentation well) performs the coronary angiogram, it is often reasonable to proceed immediately to *ad hoc* PCI provided that none of the circumstances listed in Table 1 apply, consistent with the position statement from SCAI for *ad hoc* PCI:

**Table 1: Features that do not support *ad hoc* PCI (* number 11 has been added to the SCAI list)**

1. High-risk/complex anatomic stable coronary disease (e.g., unprotected left main, complex multi-vessel coronary artery disease, chronic total occlusion).
2. Excessive contrast or radiation during diagnostic procedure, or anticipated during PCI.
3. Site of service (e.g., facility without onsite surgery in which the patient risk or lesion risk is high or facility lacking necessary interventional equipment).

4. Inadequate informed consent (e.g., diagnostic catheterization identifies anatomy for which the risk of PCI is significantly higher than was discussed before PCI).
5. Uncertainty regarding extent of symptoms in patients with stable ischemic heart disease.
6. Lack of evidence of ischemia and unavailability of fractional flow reserve or intravascular ultrasound.
7. Complication during diagnostic catheterisation (e.g., stroke or access site bleeding).
8. Operator or patient fatigue after diagnostic catheterisation.
9. Scheduling problems (e.g., if a new patient presents with ST-elevation as *ad hoc* PCI is being considered for a Stable patient).
10. Inadequate pre-treatment (e.g., no aspirin before diagnostic catheterization, inadequate trial of medical therapy, inadequate pre-hydration)
11. Where the decision to perform PCI is not obvious and a "pause" to consider options (medical therapy or CABG) may improve outcomes.

**12. Conclusions**

This document is a summary of a large body of work that has been performed over many years by the Task Force, Department of Health, CSANZ and independent Cardiologists to align coronary artery intervention with current best practice.

The new item descriptors have been carefully reviewed by multiple parties endeavouring to maintain the principles of the Task Force whilst mitigating any unforeseen consequences for stakeholders or barriers for patients.

CSANZ is now comfortable that the new item descriptors should not cause any significant issues when implemented. CSANZ welcomes feedback about any concerns.

## Appendix A: Angiography item descriptors. **(Note the first line in italics has been added for clarity of explanation in this document and will NOT appear in the schedule.)**

| | | |
|---|---|---|
| 38244 | *Stand-alone angiography in high-risk group.*<br>Selective coronary angiography:<br>(a) for a patient who is eligible for the service under clause 5.10.17A; and<br>(b) with placement of one or more catheters and injection of opaque material into native coronary arteries; and<br>(c) with or without left heart catheterisation, left ventriculography or aortography; and<br>(d) including all associated imaging;<br>other than a service associated with a service to which 38200, 38203, 38206, 38247, 38248, 38249, 38251 or 38252 applies (Anaes) | 920.00 |
| 38247 | *Stand-alone angiography with graft/s in high-risk group.*<br>Selective coronary and graft angiography:<br>(a) for a patient who is eligible for the service under clause 5.10.17A; and<br>(b) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and<br>(c) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and<br>(d) with or without left heart catheterisation, left ventriculography or aortography; and<br>(e) including all associated imaging;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38248, 38249, 38251 or 38252 applies (Anaes) | 1,473.95 |
| 38248 | *Stand-alone angiography in stable syndromes.*<br>Selective coronary angiography:<br>(a) for a patient who is eligible for the service under clause 5.10.17B; and<br>(b) as part of the management of the patient; and<br>(c) with placement of catheters and injection of opaque material into native coronary arteries; and<br>(d) with or without left heart catheterisation, left ventriculography or aortography; and<br>(e) including all associated imaging;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38249, 38251 or 38252 applies—applicable each 3 months (Anaes.) | 920.00 |
| 38249 | *Stand-alone angiography with graft/s in stable syndromes.*<br>Selective coronary and graft angiography: | 1,473.95 |

| | | |
|---|---|---|
| | (a) for a patient who is eligible for the service under clause 5.10.17B; and<br>(b) as part of the management of the patient; and<br>(c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and<br>(d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and<br>(e) with or without left heart catheterisation, left ventriculography or aortography; and<br>(f) including all associated imaging;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38251 or 38252 applies—applicable once each 3 months<br>(Anaes.) | |
| 38251 | *Stand-alone angiography for valvular and structural heart diseases.*<br>Selective coronary angiography:<br>(a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and<br>(b) as part of the management of the patient for:<br>(i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or<br>(ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and<br>(c) with placement of catheters and injection of opaque material into native coronary arteries; and<br>(d) with or without left heart catheterisation, left ventriculography or aortography; and<br>(e) including all associated imaging;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38252 applies—applicable once each 12 months<br>(Anaes.) | 920.00 |
| 38252 | *Stand-alone angiography with graft/s for valvular and structural heart diseases.*<br>Selective coronary and graft angiography:<br>(a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and<br>(b) as part of the management of the patient for:<br>(i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or<br>(ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and<br>(c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and<br>(d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and<br>(e) with or without left heart catheterisation, left ventriculography or aortography; and<br>(f) including all associated imaging; | 1,473.95 |

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38251 applies—applicable once each 12 months (Anaes.)

## Appendix B: Angiography proceeding to PCI item descriptors. **(Note the first line in italics has been added for clarity of explanation in this document and will NOT appear in the schedule.)**

| | | |
|---|---|---|
| 38307 | *Angiography proceeding to single territory PCI in ACS/ high risk group.*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and<br>(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and<br>(b) including selective coronary angiography and all associated imaging, catheter and contrast; and<br>(c) including either or both:<br>(i) percutaneous angioplasty;<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on one coronary vascular territory; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | 1,844.60 |
| 38308 | *Angiography proceeding to double territory PCI in ACS/ high risk group.*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and<br>(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and<br>(b) including selective coronary angiography and all associated imaging, catheter and contrast; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on 2 coronary vascular territories; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | 2,122.25 |
| 38310 | *Angiography proceeding to triple territory PCI in ACS/ high risk group*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and | 2,399.90 |

(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and

(b) including selective coronary angiography and all associated imaging, catheter and contrast; and

(c) including either or both:

(i) percutaneous angioplasty; and

(ii) transluminal insertion of one or more stents; and

(d) performed on 3 coronary vascular territories; and

(e) excluding aftercare;

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)

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38311 *Angiography proceeding to single territory PCI in stable syndromes* 1,844.60

Percutaneous coronary intervention:

(a) for a patient:

(i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and

(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and

(b) including selective coronary angiography and all associated imaging, catheter and contrast; and

(c) including either or both:

(i) percutaneous angioplasty; and

(ii) transluminal insertion of one or more stents; and

(d) performed on one coronary vascular territory; and

(e) excluding aftercare;

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)

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38313 *Angiography proceeding to double territory PCI in stable syndromes* 2,122.25

Percutaneous coronary intervention:

(a) for a patient:

(i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and

(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and

(b) including selective coronary angiography and all associated imaging, catheter and contrast; and

(c) including either or both:

(i) percutaneous angioplasty; and

(ii) transluminal insertion of one or more stents; and

(d) performed on 2 coronary vascular territories; and

(e) excluding aftercare;

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)

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38314 *Angiography proceeding to triple territory PCI in stable syndromes* 2,399.90

Percutaneous coronary intervention:

(a) for a patient:

(i) eligible for the service under clause 5.10.17C; and

(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and

(b) including selective coronary angiography and all associated imaging, catheter and contrast; and

(c) including either or both:

(i) percutaneous angioplasty; and

(ii) transluminal insertion of one or more stents; and

(c) performed on 3 coronary vascular territories; and

(e) excluding aftercare;

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)

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## Appendix C: Elective / Staged PCI descriptors **(Note the first line in italics has been added for clarity of explanation in this document and will NOT appear in the schedule.)**

| | | |
|---|---|---|
| 38316 | *Elective /Staged single territory PCI in ACS/ high risk group*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on one coronary vascular territory; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | 1,648.95 |
| 38317 | *Elective /Staged double territory PCI in ACS/ high risk group*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on 2 coronary vascular territories; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | 2,088.80 |
| 38319 | *Elective /Staged triple territory PCI in ACS/ high risk group*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17A; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and | 2,366.45 |

| | | |
|---|---|---|
| | (d) performed on 3 coronary vascular territories; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | |
| 38320 | *Elective /Staged single territory PCI in stable syndromes*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on one coronary vascular territory; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (Anaes.) (Assist.) | 1,648.95 |
| 38322 | *Elective /Staged double territory PCI in stable syndromes*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on 2 coronary vascular territories; and<br>(e) excluding aftercare;<br>other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (Anaes.) (Assist.) | 2,088.80 |
| 38323 | *Elective /Staged triple territory PCI in stable syndromes*<br>Percutaneous coronary intervention:<br>(a) for a patient:<br>(i) eligible for the service under clause 5.10.17C; and<br>(ii) for whom selective coronary angiography has been completed in the previous 3 months; and<br>(b) including any associated coronary angiography; and<br>(c) including either or both:<br>(i) percutaneous angioplasty; and<br>(ii) transluminal insertion of one or more stents; and<br>(d) performed on 3 coronary vascular territories; and<br>(e) excluding aftercare; | 2,366.45 |

other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (Anaes.) (Assist.)

## Appendix D: Add on items **(Note the first line in italics has been added for clarity of explanation in this document and will NOT appear in the schedule. As these items are performed in association with angiography or PCI, multiple procedure rule will apply)**

| | | |
|---|---|---|
| 38309 | *Rotational atherectomy , actual fee will be reduced by multiple items rule and will typically be 50% of fee shown, eg $625.35*<br><br>Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if:<br>(a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and<br>(b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies<br>Applicable only once on each occasion the service is performed (Anaes.) (Assist.) | 1,250.70 |
| 38254 | *Right heart catheter during angiography, actual fee will be reduced by multiple items rule and will typically be 50% of fee shown, eg $231.75*<br><br>Right heart catheterisation:<br>(a) performed at the same time as service to which item 38244, 38247, 38248, 38249, 38251 or 38252 applies; and<br>(b) including any of the following (if performed):<br>(i) fluoroscopy;<br>(ii) oximetry;<br>(iii) dye dilution curves;<br>(iv) cardiac output measurement;<br>(v) shunt detection;<br>(vi) exercise stress test<br>(Anaes.) | 463.50 |
| 38241 | *Pressure wire, FFR/iFR or equivalent, can be claimed per territory with multiple items rule*<br><br>Use of a coronary pressure wire, if the service is:<br>(a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and<br>(b) to measure fractional flow reserve, non-hyperaemic pressure ratios or coronary flow reserve in intermediate coronary artery or graft lesions (stenosis of 50 to 70%); and<br>(c) to determine whether revascularisation is appropriate, if previous functional imaging:<br>(i) has not been performed; or | 488.70 |

| | | |
|---|---|---|
| | (ii) has been performed but the results are inconclusive or do not apply to the vessel being interrogated; and<br>(d) performed on one or more coronary vascular territories<br>(Anaes.) | |

## Appendix E: Additional Standalone Items (cannot be claimed with angiography)

| | | |
|---|---|---|
| 38200 | Right heart catheterisation with any one or more of the following:<br>(a) fluoroscopy;<br>(b) oximetry;<br>(c) dye dilution curves;<br>(d) cardiac output measurement by any method;<br>(e) shunt detection;<br>(f) exercise stress test;<br>other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (Anaes.) | 463.50 |
| 38203 | Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture, with any one or more of the following:<br>(a) fluoroscopy;<br>(b) oximetry;<br>(c) dye dilution curves;<br>(d) cardiac output measurements by any method;<br>(e) shunt detection;<br>(f) exercise stress test;<br>other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) | 553.10 |
| 38206 | Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following:<br>(a) fluoroscopy;<br>(b) oximetry;<br>(c) dye dilution curves;<br>(d) cardiac output measurements by any method;<br>(e) shunt detection;<br>(f) exercise stress test;<br>other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) | 668.70 |