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**Consultation Survey on MSAC Application 1546 Abdominoplasty with repair of rectus diastasis (aka rectus divarication) following pregnancy**

**(Version 0.1)**

This feedback survey relates to the application and Population, Intervention, Comparator and Outcome (PICO) Confirmation for new and amended requests for public funding (including but not limited to the Medicare Benefits Schedule (MBS)).

Please use this template, to prepare your feedback on the application form and/or the PICO Confirmation. You are welcome to provide feedback from either a personal or group perspective for consideration by the Department of Health when the application is being reviewed.

The data collected will be used to inform the Medical Services Advisory Committee (MSAC) process to ensure that when proposed healthcare interventions are assessed for public funding in Australia, they are patient focused and seek to achieve best value.

This feedback survey should take approximately 15 minutes to complete.

You may also wish to supplement your responses with further documentation or diagrams or other information to assist the Department in considering your feedback.

Thank you for taking the time to provide valuable feedback.

Responses may be provided to the MSAC, its subcommittees, a health technology assessment group and the applicant. Should you require de-identification please contact the Australian Society of Plastic Surgeons (ASPS) as the applicant.

While stakeholder feedback is used to inform the application process, you should be aware that your feedback may be used more broadly by the applicant.

**Please reply to the applicant – Australian Society of Plastic Surgery:**

**Ms Kimiko Grayson, MBS Specialist Officer**

**Email: mbs@plasticsurgery.org.au**

# PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. **Respondent details**

Name:

Email:

Phone No:

1. Is the feedback being provided on an individual basis or by a collective group? (please select)

**Individual**

**Collective Group**

**(a) If individual, specify the name of the organisation you work for**

**(b) If collective group, specify the name of the group**

1. How would you best identify yourself?

**General Practitioner**

**Specialist**

**Researcher**

**Consumer/Patient**

**Care giver**

**Other**

1. If other, please specify

# PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

1. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application form
2. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?
3. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?
4. What other benefits can you see from having this intervention publically funded on the Medicare Benefits Schedule (MBS)?
5. What other services do you believe need to be delivered before or after this intervention, eg Dietician, Pathology etc?

# PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

1. Do you agree or disagree with the proposed population(s) for the proposed medical service as specified below?

Patients with an anterior abdominal wall defect that is a consequence of pregnancy. Additionally, the patient must also:

* be at least 12 months post-partum;
* have a diastasis of at least 3cm (as measured by Vernier callipers or appropriate diagnostic imaging); and
* have symptoms of abdominal discomfort on functional use and low back pain.

**Strongly Agree**

**Agree**

**Disagree**

**Strongly Disagree**

1. Specify why or why not:
2. Have all the associated interventions been adequately captured in Part 6b of the application form?

**Yes**

**No**

1. Please explain:
2. Do you agree or disagree that the comparator(s) to the proposed medical service as specified in Part 6c of the application form?

**Strongly Agree**

**Agree**

**Disagree**

**Strongly Disagree**

1. Do you agree or disagree with the clinical claim made for the proposed medical service as specified in Part 6d of the application form?

**Strongly Agree**

**Agree**

**Disagree**

**Strongly Disagree**

1. Specify why or why not:

# PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

1. Do you agree with the proposed MBS item descriptor:

Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, and where it can be demonstrated, by measurement with Vernier calipers at a specialist consultation or with diagnostic imaging, that the patient has an abdominal wall defect as a consequence of pregnancy and must:

1. not be receiving this service within 12 months after the end of a pregnancy (once in a lifetime);
2. have a diastasis of at least 3cm (measured by Vernier callipers or diagnostic imaging); and
3. have documented symptoms (in the case notes) of pain or discomfort at the site of the diastasis in the abdominal wall during functional use and lower back pain.

Multiple Operation Rule (Anaes.) (Assist.)

**Fee:** $985.70 **Benefit**: 75% = $739.30

**Strongly Agree**

**Agree**

**Disagree**

**Strongly Disagree**

1. Specify why or why not:
2. Do you agree or disagree with the proposed MBS fee, as provided in question 13 above?

**Strongly Agree**

**Agree**

**Disagree**

**Strongly Disagree**

1. Specify why or why not:

# PART 5 – ADDITIONAL COMMENTS

1. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?
2. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

**Again, thank you for taking the time to provide valuable feedback.**