Australian Society *of* Plastic Surgeons

FAQ's for Patients regarding the repair of postpartum rectus diastasis (muscle split)

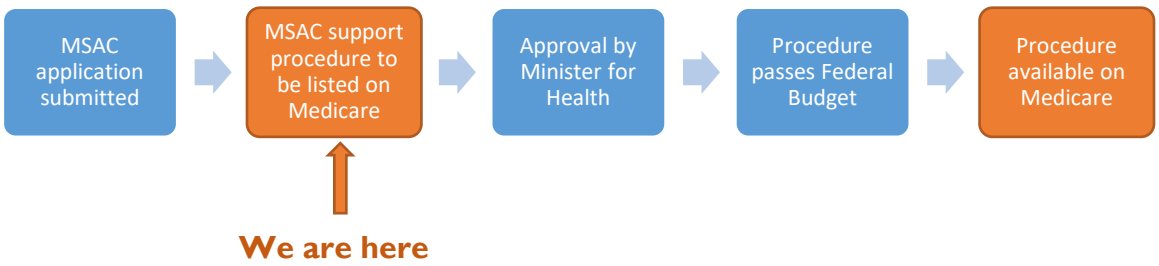
(Version 1 30 September 2021)

What do the recent announcements around the surgical repair of rectus diastasis ('abdominoplasty') mean?

The Medical Services Advisory Committee (MSAC) is the authoritative body that advises the Minister for Health and the Commonwealth Department of Health on what procedures should be partially covered by Medicare (i.e. subsidised). Surgery to sew the abdominal muscles back together after pregnancy used to be covered by Medicare but was removed from the Medicare Benefits Schedule (MBS) in 2016 after concerns it was being misused for cosmetic purposes.

After submitting an initially unsuccessful application in 2018 to MSAC, ASPS have just received the welcome news that our re-application/second application has been supported.
The fact that MSAC has made a ruling to support an MBS item for the repair of rectus diastasis (tummy muscle split) for some women after pregnancy is a major win for those women, but it is not the final step in the process. The Minister can still decide to refuse to accept the advice of MSAC (although this is very rare) and final approval always depends on whether the item is passed in the Federal Budget. In addition, the Department of Health and Medicare, reserve the right to make minor adjustments to the eligibility criteria or fees associated with the procedure further down the track.

As an indication of what to expect from here, ASPS have previously submitted a successful MSAC application which was supported by MSAC but took over 12 months to become available to patients. So please hold tight. Below is a brief summary of what to expect ***if*** each 'step' in the process is approved or supported.



ASPS have also developed a more detailed timeline which is available to view on our dedicated webpage to show the process to date. As you can see it has been a long road and involved a lot of stakeholders, including the thousands of women and medical practitioners who provided their feedback.

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What is the eligibility criteria in order to receive the Medicare subsidy?

Given the Medicare item is subject to change if it passes the Federal Budget, we don't yet have final eligibility criteria. However, MSAC supported the proposed item descriptor put forward by ASPS which included the following criteria:

- **Cause.** The rectus diastasis (tummy muscle split) was caused by pregnancy
- **Timing**. The patient must be at least 12 months post-partum at the time of receiving the surgery
- **Gap measurement.** The gap between abdominal muscles must be at least 3cm as evidenced by an ultrasound
- **Symptoms.** The patient must have documented symptoms of pain or discomfort at the site and/or low back pain or urinary symptoms
- **Other treatment failed.** The patient must have tried and failed to respond to non-surgical treatment options such as physiotherapy.
    - Other examples of non-surgical treatment may be: symptomatic management with pain medication, lower back braces, lifestyle changes, physiotherapy and/or exercise.

Who decides if I'm eligible?

To qualify for the procedure under Medicare, the decision ultimately sits with the Specialist Plastic Surgeon you see to determine whether you meet the criteria.
However, ASPS expect the following medical practitioners would have also been consulted with. ASPS would also expect those practitioners would provide the operating surgeon with confirmation of whether each patient may be eligible.

1. GP would have been seen for non-surgical management and treatment options. GPs would also need to make the referral to the Specialist Plastic Surgeon who will perform the surgery.
2. Physiotherapist or other Allied Health practitioner such as an Exercise Physiologist may be seen if the patient tried physiotherapy or exercise programs
3. Radiologist must have conducted an ultrasound to measure and confirm the inter rectus diameter (the size of the gap between abdominal muscles)

What does being covered by Medicare mean to me & what are the likely costs?

Medicare is a Commonwealth Government scheme to provide rebates for treatment by registered health providers for procedures that have been agreed upon as affecting people's health as well as for consultations and other health services. All Australian permanent residents and citizens have access to Medicare. However, for temporary residents or visitors, access to Medicare depends on your specific visa conditions. If you do not have Medicare or Medicare rights, this recent announcement won't change how you access this procedure and you will still need to pay full fees. The factors listed below will impact how much you will pay.

- Medicare eligibility
- Private Health Insurance status and coverage
- Surgeon's fee

- Final amount Medicare cover (this is called the 'Schedule Fee'). The current fee for the same procedure but for massive weight loss or after removal of a large tumour is $1,025 – this is an indication only.
- Hospital or surgical facility costs
- Anaesthesia fees
- Prescriptions for medication
- Post-surgery garments
- Medical tests, such as ultrasounds
- Any costs associated with non-surgical prior treatment, such as physiotherapy

Your surgeon should be able to discuss this in more detail with you.

Private Hospitals & Medicare explained. Private Hospitals work with both Medicare and Private Health Insurance (PHI) companies, so if you are eligible for the procedure, have Private Health Insurance, and have the procedure in a private hospital, Medicare and your Insurer may contribute to the total fees on your behalf, leaving you with a smaller gap fee or out-of-pocket expense.
So after Medicare pay the hospital and your Insurance pays the hospital, you may only need to pay a small fee. But this depends on the factors listed above.

Public Hospitals & Medicare explained. Public Hospitals are run and funded by State and Territory Governments and are a completely separate system from Medicare. State and Territory Governments often have their own "*elective surgery policies*" which may sometimes reflect what is included on the Medicare Benefits Schedule but also may not. So depending on the State or Territory you have this procedure in, this change may or may not affect your access to post-partum abdominoplasty in a public hospital.

I have existing Private Health Insurance

Operating surgeons charge different amounts. If you have private health insurance and the policy you have covers *plastic and reconstructive surgery (medically necessary),* you may still be out of pocket some expense but this amount may be minimal in comparison to having no health insurance. Most plastic and reconstructive surgery (medically necessary) is only covered where the insurance-holder has Silver-level cover or above. This means if you have Bronze-level cover it is highly unlikely your insurer will contribute to this procedure. ASPS suggest you start looking into your private health insurance coverage now to decide whether it will be more cost-effective to increase your coverage prior to commencing with surgery. This will depend entirely on your individual circumstances.

I do not have Private Health Insurance

If you are not in a position to have surgery done as a private patient, you *may* still be able to access surgery in a public hospital in your area.
The first step is to discuss this with your GP who may know the "elective surgery policy" that covers your state or territory. If your GP feels you are likely to meet the criteria set out in the policy, they may then advise whether they feel that it is appropriate to refer you to a Specialist Plastic Surgeon for outpatient assessment.

Unfortunately, the time between referral and assessment in the public system for this sort of condition is often several years. Once you have the assessment by the specialist, they will then be able to tell you whether you meet local criteria to undergo surgery in the public system. If you are eligible, you are then likely to wait at least another 12 months for the surgery. In the public sector, it is important to know that you may not have the surgery performed by the same surgeon that initially assesses you.

If you do not have private health insurance and do not satisfy the criteria for having the surgery in a public hospital, you may consider going to a private hospital to have the surgery. If you chose a private hospital then Medicare will pay the hospital 75% of the Schedule Fee amount, and you would pay the remainder. The factors listed above will also determine how much you will be charged after the Medicare rebate.

If you are in a position to, you may like to start looking into whether taking out private health insurance now (bearing in mind wait periods) is worth it for you. For example, if you get a policy with a 12 month wait period but it will cover a large amount towards plastic and reconstructive surgery (medically necessary), then paying for 12 months of premiums may be cheaper than paying the full gap fee later down the track. Or it could be more expensive. Either way, it's worth looking into it now whilst we wait for the item to become available.

ASPS suggest you contact your GP, Specialist Plastic Surgeon and Private Health Insurer to discuss your circumstances.

What if I just don't like the look of my tummy after pregnancy?

Medicare does not cover cosmetic procedures. A 'tummy tuck' is considered cosmetic. Those women seeking to improve the aesthetic appearance of their bodies rather than address a functional impairment will continue to have to pay the full cost of this procedure with no subsidy by Medicare or private health insurers. This is why there are such tight eligibility criteria - to ensure it cannot be misused at the expense of public money. We know that the procedure was removed from the MBS in 2016 due to concerns it was being used for cosmetic purposes. So we are urging patients and surgeons to ensure the criteria is clearly met before claiming this item to avoid the misuse of Medicare funding.

Medicare will also be conducting a review of usage of this procedure 2 years after it is implemented. If there is concern it is being misused for cosmetic purposes, we risk it being removed once again from the MBS to the detriment of those women who genuinely need this procedure for *functional* reasons.

When can I access this through Medicare?

As is indicated in the Timeline provided, this is a long and complex process. As an indication of what to expect from here, ASPS have previously submitted an MSAC application which was supported by MSAC but took over 12 months to become available to patients. So please hold tight. Below is a summary of what to expect ***if*** each 'step' in the process is approved or supported. The main things to note are that the next Federal Budget is not likely to occur until mid-2022. So we anticipate the item will only be available in late 2022 but do not know exact timeframes.

What can I do to prepare for this surgery whilst awaiting its availability?

We know it will probably take about a year for this procedure to be listed on Medicare so there are a few things you can do to start preparing for it, if you think you may be eligible.

1. **See your GP** to discuss non-surgical treatment options or management of symptoms. These may include, but are not limited to: physiotherapy and/or exercise, symptomatic management with pain medication, lifestyle changes, lower back braces, etc. Bear in mind it will most likely be a requirement that you have tried to treat your rectus diastasis with non-surgical options before considering surgery. Your GP may refer you to a physiotherapist or other health professional to try non-surgical treatment options.
2. **Look into your Private Health Insurance options** so any wait times for claiming certain procedures can be ticking over whilst awaiting this procedure to become available. See the above question - *What does being covered by Medicare mean to me & what are the likely costs?* For some information that might help you decide.

Where can I find authoritative information?

ASPS will be updating information as we receive it from the Department of Health on our webpage dedicated to this announcement and procedure. We suggest you use ASPS information as we will be updated directly by the Department of Health who are responsible for overseeing MSAC's support through to implementation onto Medicare.

How can I make sure I don't miss out on important updates and details?

ASPS have generated a contacts list on our dedicated webpage so please sign up if you want important updates. This may include links to useful resources, any update on timing for availability, details about eligibility criteria, and other information relevant to this new Medicare item.

My doctor tells me I won't be eligible. What can I do now?

Given the tight eligibility criteria for this item number, ASPS expect there will be some women who may be experiencing some symptoms related to rectus diastasis but will not be eligible for this abdominoplasty under Medicare. If you do not meet the Medicare eligibility criteria you can still have this procedure but will have to self-fund the full costs. Below are some other treatment or management options that may be applicable. As with any medical or health issue, this is just a

list of *some* of the possible options and whether they are the right options for you will require a detailed discussion with your health care provider so your individual circumstances can be considered.

- GP management of symptoms
- Physiotherapy programs tailored to you and your symptoms (rectus diastasis, urinary incontinence, back pain etc.)
- Exercise programs aimed at improving core stability and functionality
- Sometimes rectus diastasis and hernias are related and there are some hernia procedures covered by Medicare so it might be worth discussing whether your symptoms could be managed through hernia repair with your GP.
- There are also currently existing item numbers for abdominoplasty but they are limited to patients who have experienced massive weight loss (not postpartum weight loss) and where there was an intraabdominal tumour that caused the rectus diastasis.

We understand that finding out about this news and discovering you may not be eligible can be hard to hear, so encourage you to talk with family, friends, and health care providers. Don't forget you can also call Lifeline on 13 11 14.