FAQ's for ASPS Members & Providers regarding MSAC's recent decision to support the reinstatement of abdominoplasty with repair of rectus diastasis following pregnancy onto the MBS

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What do the recent announcements around the Medical Services Advisory Committee (MSAC) supporting surgical repair of rectus diastasis 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 covered on the Medical Benefits Schedule (MBS). Abdominoplasty to repair rectus diastasis after pregnancy used to be covered on the MBS but was removed in 2016 after concerns it was being misused for cosmetic purposes.

After submitting an initially unsuccessful application in 2018 to MSAC, ASPS received the welcome news that our re-application/second application had been supported and has since successfully now passed the federal budget.

Allocation in the 2022-23 Federal Budget for funds to support an item number for the procedure has been officially announced. The item number 30175 came into effect from 1 July 2022.

This represents a major win for the women who experience post-partum rectus diastasis.

What is the item descriptor that MSAC has decided to support?

MSAC support the following proposed item descriptor and associated Explanatory Note.

Category 3017X – Category 3 – Therapeutic Procedures
Group T8 – surgical operations Subgroup 1 – general Radical abdominoplasty, with repair of rectus diastasis, excision of skin and subcutaneous tissue, and transposition of umbilicus, not being a laparoscopic procedure, not being a service associated with a service to which item 30165, 30651, 30655, 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, and where it can be demonstrated, that the patient has an abdominal wall defect as a consequence of pregnancy and must: a) not be receiving this service within 12 months after the end of a pregnancy;

b) have a diastasis of at least 3cm measured by diagnostic imaging; and c) have documented symptoms of at least moderate severity of pain or discomfort at the site of the diastasis in the abdominal wall during functional use and/or low back pain or urinary symptoms likely due to rectus diastasis; and d) have failed to respond to non-surgical conservative treatment including physiotherapy Applicable once per lifetime Multiple Operation Rule (Anaes.) (Assist.) (H) (See para TN.8.X of explanatory notes to this Category)
Fee: $1,025.60 **Benefit**: 75% = $769.20

TN.8.XX
In the context of eligibility for item 3017X, acceptable examples of conservative non-surgical treatment include symptomatic management with pain medication, lower back braces, lifestyle changes, physiotherapy and/or exercise. Diagnostic imaging, documented symptoms of pain and discomfort, and documented failure to respond to non-surgical conservative treatment must all be documented in patient notes.

Below is a summary of the proposed criteria supported by MSAC.

- **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.

How has this win been achieved?

Since 2016, when women with post-partum rectus diastasis were removed as an eligible patient group from the MBS, ASPS has been working hard to get access for this particular group of patients reinstated. This involved working with external stakeholders such as the Department of Health, MSAC, and Minister for Health, patient support groups, Government Ministers as well as responding to various media requests. It also involved a number of internal ASPS initiatives to ensure the application put forward was the most robust and sound it could be for presentation to MSAC. ASPS has funded a part-time 'MBS Officer', and in the last 6 months an

HTA specialist consultant to help with various stages of the 3 year application process. Additionally, members of the ASPS Council have contributed their time and expertise to researching the issues and constructing the written, verbal and strategic components of the application.

In addition to the MSAC application itself, the success of the application is due to the parallel community voice. This was thanks to the tremendous response to the consultation survey which accompanied the application, as well as the unrelated but serendipitous petition presented to Parliament which was authored by Sydney woman and now ASPS Council's Community Representative, Ms Kerrie Edwards. Ms Edwards' local MP Dr Fiona Martin offered to present this petition to Parliament on behalf of the 13,000 signatories.

There was unprecedented representation and response from a variety of medical practitioners and health care providers, as well as patients in completing the consultation survey, and it is unlikely that this item would have gained MSAC's support without the impressive voice of the general community and the doctors looking after these women. A huge thankyou is due to all those who completed a survey and/or signed Ms Edwards' petition to Parliament.

What can I advise my patients to prepare for the procedure being on Medicare?

ASPS have also produced an FAQ for patients which we invite you to share.

1. *Look at their private health insurance status and coverage*

Being covered by the MBS only means there is a set subsidy for undergoing the procedure. In most cases there will still be an out-of-pocket expense. Subject to final administrative and legislative factors, this procedure will likely be included in Private Health Insurance cover for Bronze or Silver level policies. We now know that the item number will come into effect as of 1st of July 2022. Common PHI covers usually dictate 12 month waiting periods. For those who are likely to be eligible for the procedure but do not have private health insurance, they may wish to consider taking out a policy so that waiting periods are ticking over. If they already have cover, they may benefit from checking whether their policy covers Plastic and Reconstructive Surgery (medically necessary).
We suggest you direct your patient to the Patient FAQ's for more detail on this point as there are factors only they will have the answers to for what the most suitable option for them and their families is.

2. *Start exploring non-surgical treatment options*

Part (d) of the proposed item descriptor states the patient must:

> d) have failed to respond to non-surgical conservative treatment including physiotherapy...

The Explanatory Note supported by MSAC states:

In the context of eligibility for item 3017X, acceptable examples of conservative non-surgical treatment include symptomatic management with pain medication, lower back braces, lifestyle changes, physiotherapy and/or exercise.

Diagnostic imaging, documented symptoms of pain and discomfort, and documented failure to respond to non-surgical conservative treatment must all be documented in patient notes.

As such, GPs or other health professionals providing care to women suffering post-partum RD may wish to explore such non-surgical treatment prior to referring their patients for surgery.

3. Begin dialogue with appropriate providers and build evidence of criteria being met

Each patient who ultimately undergoes this procedure under Medicare will need to have met the eligibility criteria outlined in the descriptor above. As a potential provider for a patient seeking this procedure, you can begin to link your patient with all relevant practitioners who may contribute to building and assessing the evidentiary requirements in order to meet eligibility for a Medicare subsidy. This may include:

i. GP for non-surgical treatment and management
ii. Radiologist to confirm inter rectus distance (IRD),
iii. Physiotherapist or other allied health providers to manage symptoms, and
iv. Specialist Plastic Surgeons to perform the procedure.

What evidence is required to show a patient has trialed non-surgical, conservative treatment inc. physiotherapy?

A letter from the treating physiotherapist or the GP referral stating a history of physiotherapy and would be sufficient. Non conservative may also mean being fitted for a back brace by an allied health professional and in this event: a referral letter from the GP with back pain noted is advisable. Many practices are obtaining both letters along with the ultrasound. This three pronged approach is advisable to meet the requirements for 30175.

Can intra-op imaging be used to qualify for 30175?

The item descriptor states that diagnostic imaging must be used to provide diastis recti. During the MSAC process there was much debate about types of measurement and what was most accurate, but also what was least prone to misuse. The item descriptor refers to "diagnostic imaging" which means that a radiologist must be involved. There is also more in the peer-reviewed literature about ultrasound measured rectus diastasis and virtually nothing on photographically measured diastasis. Clinical photography is also highly variable and amenable to modification by software. In addition, the panel that used to review clinical photographs in relation to patients having surgery within the Dept of Health has now been dismantled, so they would have difficulty finding a mechanism to review the photographs.

We know that from time to time what is found at ultrasound may vary from intra-op but to qualify for 30175, diagnostic imaging must be used as the imaging modality.

Where can I find authoritative information?

As the formal applicant to MSAC, ASPS will be where you can find the most accurate and up-to-date information. ASPS will be updating information as we receive it from the Department of Health who are responsible for overseeing the implementation of this item onto Medicare. We have created a dedicated webpage for this announcement and procedure. We invite all providers to also use ASPS resources to share with your patients and networks. We hope that having a consistent message to the public around what this procedure *will* be and what it *will not* be (i.e. cosmetic) can hopefully avoid any risk associated with public misinterpretation and will help manage expectations of when this procedure will be available on the MBS and what eligibility criteria will be. Examples of resources available to you and your patients include:

ASPS Members:

- In addition to the publically-available resources listed below, ASPS Members will receive email announcements and information as soon as it becomes available to ASPS and in the monthly newsletters. This will include anticipated implementation dates, item details (criteria, fees and evidentiary requirements), important messaging for patients, and messages from the President and Vice-President.

Public information:

- Dedicated webpage which will host all resources, information and links that are publically available
- FAQ for Patients which will also be updated as circumstances change
- Social media material for you to share on your own socials
- Contact form to ensure you are kept up to date with progress on this application via email
- Links to Medicare Online or other Departmental websites which will contain important information or detail, such as Factsheets prior to item availability.

How can I make sure I don't miss out on important updates and details that impact on my patients and my work?

ASPS Members will be updated via the usual ASPS channels: email announcements, newsletters, and social media updates.

Will women wanting a 'tummy tuck' be able to use this item number?

No. Medicare does not cover cosmetic procedures. A 'tummy tuck' is considered cosmetic whereas this procedure is a clinically necessary procedure in response to a functional need (i.e. it is 'medically necessary'). This is why there is 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 risk of cosmetic leakage.

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.

My patient appears to be ineligible. What can they do now?

Given the tight eligibility criteria for this item number to prevent cosmetic leakage, 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. A woman who does not meet the Medicare eligibility criteria 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. Whether they are the right options for your patient will require your clinical judgment against the patient's individual circumstances:

- GP management of symptoms, for example, with pain medication or lower back braces, lifestyle changes, etc.
- Physiotherapy programs for presenting symptoms (rectus diastasis, urinary incontinence, back pain etc)
- Exercise programs aimed at improving core stability and functionality
- Consider whether the patient meets hernia repair MBS item requirements. There is some evidence to suggest that hernia and rectus diastasis are concomitant in certain cases. There are already-existing item numbers for repair of hernias.
- Consider whether your patient meets the already-existing abdominoplasty items – items 30176 and 30177. These are for massive or significant weight loss and after removal of an intraabdominal or pelvic tumour.

My question isn't answered here.

If you have a question that has not been answered here, please contact the ASPS Office at info@plasticsurgery.org.au.