MBS Review Advisory Committee

Surgical Assistants

Final Report

November 2022

IMPORTANT NOTES

1. This report does not constitute the final position on these items, which is subject to:

- consideration by the Minister for Health and Aged Care, and
- the Government.

2. Following consultation with stakeholders, the working group developed the views and recommendations in this report for consideration by the Medicare Benefits Schedule Review Advisory Committee (MRAC).
3. Should MRAC have any eliminations, amendments or commentary from the report presented by the working group, they will be captured in boxed comments in the body of the report, as follows:

[Working Group] Recommendation [#] – MRAC advice and rationale

Contents

Summary

In Australia, surgeons can choose their own surgical assistant – someone who assists them during procedures. This is often someone with trusted clinical skill and with whom the surgeon has established a good working relationship.

Surgical assistants can set their own fees. Currently, if a surgeon chooses a surgical assistant who is medically trained (called a medical surgical assistant), such as another surgeon or a general practitioner (GP), patients can be reimbursed some of the cost of the assistant through the Medicare Benefits Schedule (MBS). However, if the surgical assistant is not medically trained (called a non-medical surgical assistant), such as a nurse, patients must pay for the surgical assistant out of their own pocket.

Having to pay out-of-pocket costs for a non-medical surgical assistant, on top of other out-of-pocket fees that may be associated with private services, potentially drives more patients to wait to have surgery in public hospitals, where there is no out-of-pocket expense for the patient. This not only puts more pressure on the public system but can result in avoidable suffering and deterioration of the patient's condition while they wait.

The MBS Review Advisory Committee (MRAC) established the Surgical Assistant Working Group (SAWG) to consider two issues:

- whether medical surgical assistants are charging patients excessive fees and, if so, what could be done to address the situation
- whether patients should receive a Medicare rebate when a surgeon chooses to use an appropriately experienced and qualified non-medical surgical assistant.

For the first issue, there were no data to support claims that surgical assistants are charging patients excessive fees for their services. Therefore, the SAWG does not recommend any changes to the current billing arrangements.

For the second issue, the SAWG recommends that patients should be reimbursed by Medicare if they agree to have a suitably qualified non-medical surgical assistant. The SAWG noted that there is a lack of available medical surgical assistants in both rural and metropolitan areas. If non-medical surgical assistants could access surgical assistant MBS items, it would reduce out-of-pocket costs to patients and ensure that all patients have equal access to reimbursement.

Acronyms

ACNP	Australian College of Nurse Practitioners
AHPRA	Australian Health Practitioner Regulation Agency
AQF level 8 Certificate)	Australian Qualifications Framework level 8 (Graduate Diploma or
GP	general practitioner
MBS	Medicare Benefits Schedule
MRAC	MBS Review Advisory Committee
MSAC	Medical Services Advisory Committee
NMBA	Nursing and Midwifery Board of Australia
NP	nurse practitioner
PARC	Principles and Rules Committee
PIR	post-implementation review
PNSA	perioperative nurse surgical assistant
SAWG	Surgical Assistant Working Group

Preamble

Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies, and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MBS Review Advisory Committee (MRAC). The Committee's role is to provide independent clinical, professional and consumer advice to Government on:

- opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
- the safety and efficacy of existing MBS items
- implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is listed in Table 1.

Table 1 MBS Review Advisory Committee members, November 2022

Member	Speciality
Conjoint Professor Anne Duggan (Chair)	Policy and Clinical Advisor / Gastroenterology
Ms Jo Watson (Deputy Chair)	Consumer Representative
Dr Jason Agostino	Indigenous Health
Dr Matt Andrews	Radiology
Professor John Atherton	Cardiology
Professor Wendy Brown	General Surgeon – Upper Gastrointestinal and Bariatric Surgery
Professor Adam Elshaug	Health Services / Systems Research
Ms Margaret Foulds	Psychology
Associate Professor Sally Green	Health Services / Systems Research
Dr Chris Helms	Nurse Practitioner
Professor Harriet Hiscock	Paediatrics
Professor Anthony Lawler	Health Services Administration / Emergency Medicine
Ms Alison Marcus	Consumer Representative
Associate Professor Elizabeth Marles	General Practice / Indigenous Health
Dr Sue Masel	Rural General Practice
Professor Christobel Saunders	General Surgeon – Breast Cancer and Reconstructive Surgery
Associate Professor Ken Sikaris	Pathology

Member	Speciality
Ms Robyn Stephen	Paediatric Speech Pathology
Associate Professor Angus Turner	Ophthalmology / Rural and Remote Medicine
Professor Christopher Vertullo	Orthopaedic Surgery

MBS Continuous Review Guiding Principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
  - recognising the central role of General Practice in coordinating care
  - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
  - item descriptors and explanatory notes are designed to ensure clarity, consistency, and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)
- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term 'General Practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through Government announcement.

Information will also be made available on the Department of Health and Aged Care websites, including MBS Online, and departmental newsletters.

Surgical Assistant Working Group

The Surgical Assistant Working Group (SAWG) was established as a subgroup of the MRAC to review and advise the Committee on surgical assistant remuneration issues. The SAWG comprises MRAC members, including medical practitioners, a nurse practitioner and a consumer representative.

The SAWG met on four occasions: Friday 8 April, Tuesday 10 May, Tuesday 24 May and Friday 21 October 2022.

Summary of the issues

Surgeons may choose to engage a surgical assistant to assist them during procedures. This may be a 'medical surgical assistant', such as another surgeon or a GP, or a 'non-medical surgical assistant', such as a perioperative nurse surgical assistant (PNSA) or a nurse practitioner (NP).

Medical surgical assistants can charge a separate fee for their services against one of seven MBS items (items 51300–51318 in Group T9 – Assistance at Operations). The patient claims a benefit against the item and pays any remaining out-of-pocket costs. These MBS items are payable only for surgical assistant services provided by medical practitioners other than the surgeon, the anaesthetist, and the assistant anaesthetist. Non-medical surgical assistants do not have access to these surgical assistant MBS items, so charges for their services are passed on to the patient as an out-of-pocket cost.

On 23 March 2021, the then Minister for Health agreed that the MRAC should consider and advise on the following surgical assistant remuneration issues:

- Surgical assistant billing arrangements
- Access to surgical assistant MBS items for non-medical surgical assistants.

In July 2021, the Department of Health and Aged Care (the Department) invited stakeholders to submit preliminary MBS policy submissions to assist the MRAC in undertaking this review.

Surgical assistant billing arrangements

The Principles and Rules Committee (PARC) was established under the MBS Review Taskforce. In 2016, PARC considered the current arrangements for the remuneration of surgical assistants. PARC identified two main issues that result in patients paying variable amounts for the same surgical services and/or being unaware in advance of the total cost of surgery:

1. Separate billing of the patient by the surgeon and surgical assistant, and the surgeon's frequent lack of visibility of their assistant's billing practices.
2. Wide variability in the size of out-of-pocket costs charged by surgical assistants, including some assistants charging a higher fee than the surgeon, and large differences between the lowest, average, and highest fees charged by surgical assistants as a cohort.

PARC developed a set of draft principles and recommendations that aimed to improve fee transparency and consistency and embed proper fee relativities between primary surgeons and their assistants. More than 100 stakeholder submissions were received during consultation, with the majority rejecting the recommendations. Particularly, there was strong stakeholder objection to the primary surgeon being responsible for the fees of an assistant surgeon, and the bundling of surgical fees. There was also opposition to a proposed variable assistant fee derived from the fee(s) of the surgical item(s) claimed by the surgeon. Consumers did not express a view on the proposal, despite it being designed primarily for their benefit.

In 2019, the Taskforce recommended to government that a working group be established to further consider surgical assistant billing arrangements.

Access to surgical assistant MBS items for non-medical surgical assistants

Non-medical surgical assistant groups (specifically, PNSAs and NPs) are seeking to access existing surgical assistant MBS items (items 51300–51318 in Group T9 – Assistance at Operations; not fee differential or new MBS items). These groups argue that access is required to address issues that include:

- patients incurring inequitable out-of-pocket expenses for surgical assistance services rendered by a non-medical surgical assistant
- reduced access to surgical services in the private sector and in rural settings
- increased pressure on the public healthcare system due to the movement of patients from the private sector to public hospitals to avoid rising out-of-pocket expenses
- a shortage of GPs to provide surgical assistance
- prolonged waiting periods for surgery due to a lack of surgical assistants.

NPs have access to other MBS items, including for attendances, telehealth attendances, requesting diagnostic imaging services, and requesting and providing pathology services. NPs also have certain prescribing and referral rights. PNSAs do not have provider numbers or access to MBS items.

In 2012, the Australian Association of Nurse Surgical Assistants applied to MSAC seeking PNSA access to surgical assistance MBS items (MSAC Application 1359); however, this application was withdrawn. In January 2019, an MSAC application was submitted for consideration of NP access to surgical assistance MBS items (MSAC Application 1581). After being put on hold pending the outcome of the MBS Review, the application underwent a suitability assessment as part of the MSAC application process. The suitability assessment determined that the application should not progress to MSAC for consideration, as there was no health technology assessment question to answer. However, following a request from the Department for stakeholder submissions, the applicant of MSAC Application 1581 provided a submission seeking NP access to surgical assistant MBS items.

The SAWG notes that there is other work being undertaken by the Department that is relevant to this review – the Health Workforce Division is developing a Nurse Practitioner 10-year Plan, while the Private Health Insurance Branch is also undertaking relevant work, particularly due to implications for out-of-pocket expenses.

Surgical Assistant Working Group findings

The SAWG considered that there were no significant data indicating that surgical assistants are charging a fee more than the primary surgeon. The SAWG considered the Taskforce Recommendation to reduce the surgical assistant's fee from 20% of the surgeon's fee to 15% but noted that the majority of surgical assistants charged less than the 20%. Therefore, the SAWG determined that the issue of surgical assistant billing arrangements will be closed, with no changes recommended.

On the issue of expanding access to MBS items to include non-medical surgical assistants, the SAWG considered the submissions in line with the PICO framework (population, intervention, comparator, outcomes).

Population

The SAWG noted that while clinical need for surgical assistants appears to be met through a combination of medical and non-medical surgical assistants, the inability for non-medical surgical assistants to provide a service for which patients can receive a rebate generates an inequity of access. According to the Australian College of Nurse Practitioners (ACNP), nurses are currently providing up to 50% of surgical assisting services, and they bill separately from the surgeon. The SAWG noted that some surgeons completely bulk bill, particularly in rural areas, and the only out-of-pocket costs may be from nurse surgical assistants.

The SAWG noted that there was a need in both rural and metropolitan areas. While metropolitan areas have greater availability of surgical trainees in the public system, there are difficulties securing surgical assistance on weekends, during holidays and after hours. This issue is compounded by a lack of GP surgical assistants, which can result in medical interns without basic education or skills in surgery providing surgical assistance, raising safety, efficiency and quality issues.

The SAWG also noted anecdotal evidence that some surgeons prefer certain nurses with PNSA qualifications to provide surgical assistance over GPs or other medical practitioners, and especially medical surgical assistants whose focus is not surgery. This is becoming more common as the demand increases for experienced surgical assistants for more complicated surgeries. The preference for certain nurse surgical assistants is usually due to the experience of the nurse and an established working relationship with the surgeon.

Intervention

The SAWG noted that while expanding access to MBS surgical assisting items may lead to a growth of the non-medical surgical assistant workforce. More importantly, it will facilitate patient equity by expanding the choice of assistant and reducing out-of-pocket costs to patients, without compromising patient safety.

The SAWG noted that having nurses perform the surgical assistant role can improve and consolidate the surgical team dynamics and associated efficiencies, as experienced nurses may be more familiar with the surgical environment than many GPs or medical interns. Existing regulatory and credentialing arrangements ensure safety standards are upheld, which is supported by peer-reviewed clinical evidence available in Australia and internationally. The SAWG also noted that access to health care is improved through a skilled and willing workforce.

The SAWG noted that the choice of appropriate surgical assistant would remain with the surgeon, which would continue to determine and limit access to these MBS items. The SAWG considered that while limiting the expansion of access to surgical assistance MBS items to NPs (rather than all nurse surgical assistants; see Number of nurse practitioners and perioperative nurses that could have access to MBS items) may be simpler to implement and monitor, it may also introduce equity issues for areas where there is a lack of NPs, particularly in rural and remote areas.

The SAWG also considered that allowing non-medical surgical assistants access to MBS items would:

- improve access to healthcare through a skilled and willing workforce
- provide options for filling the gap in service
- resolve the inequity of a two-tiered payment system.

Comparator

The SAWG noted that an alternative way to meet the need of a lack of medical surgical assistants would be to increase the cohort of medical surgical assistants. The projections of the National Medical Workforce Strategy indicate a growth in the number of non-specialists 'service grade' medical graduates. However, the SAWG considered that the increase in medical surgical assistants is unlikely to happen quickly and may not address the challenges in rural settings. The SAWG also considered that such an increase may not solve the issue – given that the choice of assistant is the surgeon's, many may still prefer experienced nurses with whom they have an established working relationship.

The SAWG considered that while the rebates could be increased for T8/surgical items when surgeons use assistants who cannot bill, this was a complex solution and was subject to inappropriate use. The SAWG also considered that introducing more surgical training programs would not have an impact either, given the small number of nurses who do or can perform the surgical assistant role.

Outcomes

The SAWG considered that it was difficult to quantify the likely costs vs benefits of the non-medical surgical assistant role due to the lack of available data. The SAWG noted that the Department recently engaged KPMG to conduct a cost–benefit analysis of NP models of care in the aged care and primary health care sectors in Australia, to assess existing NP models from an economic perspective.

The report Cost benefit analysis of nurse practitioner models of care, available on the Department's website, identified key success factors and challenges of current NP models, as well as areas for potential expansion. While the KPMG report did not account for surgical assisting, the SAWG considered that it could potentially be extrapolated to this area of practice.

The SAWG considered the possibility that MBS eligibility for non-medical surgical assistants may shift some nurses currently employed by hospitals or surgeons to private billing. However, the SAWG agreed that inequity of patient access was the key consideration, and that patients should receive a rebate regardless of the person assisting the surgeon. The SAWG noted that there would be simplified billing for patients, dependent on arrangements with the surgeon. The SAWG considered there

were limited risks, given the governance of the role (including local credentialing processes and surgeon oversight).

Assessment of main issues

Impacts on other aspects of the healthcare system

Workforce impacts

The SAWG noted feedback that workforce issues, such as a lack of available medical surgical assistants, are having a negative impact on surgical assisting, and that this is not expected to improve without significant changes to the current model of care. The SAWG noted that it is important to consider the workforce from which surgical assistants are being drawn, and what impact this may have on their other settings of practice.

The SAWG noted that rural surgeons have been relying on non-medical surgical assistants for several years. Unless there is a dramatic shift of doctors to rural centres, reliance on non-medical surgical assistants in these areas is likely to increase. The SAWG noted from the ACNP that nurses are providing up to 50% of surgical assisting services in some regions of Australia, and are already funded in some instances due to need (e.g. WorkCover Queensland and Surgery Connect).

Patient care and out-of-pocket costs

The SAWG considered that the quality of service provided to patients may be increased by having a larger workforce of dedicated, well-trained surgical assistants. Decreasing the reliance on GPs for surgical assisting may also allow procedural GPs in rural and remote areas to provide a better service to their community and mitigate the GP shortage.

The SAWG considered that if there is no change to the current surgical assisting items, there is the potential for patients to move to the public system to avoid out-of-pocket costs, which would place more pressure on the public system. This could result in avoidable suffering and deterioration for patients who choose to wait for care from the public system.

The SAWG also considered there may be upwards pressure on out-of-pocket costs if rebates for nurse surgical assistants are not passed on to patients (i.e. if they are negated by increased fees). The SAWG noted that this would need to be monitored but given that the setting of fees sits with the organisation or practitioner, it would be difficult to guard against this other than through appropriate adherence to informed financial consent.

Qualifications and credentialing

The SAWG noted that there are educational regulatory governance differences between NPs with PNSA qualifications, and people with PNSA qualifications but no NP qualification. The SAWG noted that PNSA programs are not always accredited against recognised standards. Conversely, NPs are regulated as an advanced practice nursing cohort specifically endorsed by the Nursing and Midwifery Board of Australia (NMBA) and the Australian Health Practitioner Regulation Agency (AHPRA), underpinned by professional standards. The local recognition of this status is guided by the National Safety and Quality Health Service Clinical Governance Standards, specifically Actions 1.23 and 1.24, which relate to credentialing and defining the scope of practice of health practitioners. The SAWG noted that these processes are monitored and assessed

through a facility's participation in accreditation activities, as well as through jurisdictional regulatory and licensing regimes. Further, many NP surgical assistants are accredited and credentialed in each facility to work as a surgical assistant. The SAWG noted that there is consistency in the application of requirements in terms of skills and training across both public and private sectors.

The SAWG noted that while eligibility to provide surgical assistance in a facility is governed by formal credentialing processes, assistants are also chosen based on a surgeon's preference. The SAWG considered that the surgeon is the best person to assess whether someone is a good assistant, and that the concept of a team is important to a patient's care.

Number of nurse practitioners and perioperative nurses that could have access to MBS items

The SAWG noted that there are an estimated 2,500 NPs in Australia, across many fields of practice. This number is steadily growing, driven by the Nurse Practitioner Steering Committee 10-year Plan and other initiatives. By comparison, there are more than 400,000 nurses in Australia, with more than 300,000 of these being registered nurses.

The SAWG noted that while it is difficult to quantify the number of NP surgical assistants in Australia, it is estimated to be around 100, with around three-quarters working in private practice. The SAWG considered that the number of NP surgical assistants may increase, as those with a PNSA qualification (at the masters level) can expedite their pathway to NP qualifications through recognition of prior learning, but it is usually experienced nurses already working in the operating theatre who would take on the role of surgical assistant.

Metropolitan versus rural/remote

The SAWG considered that while initially limiting provider number access to those working in rural and remote areas would limit the financial impact, it is difficult to split between rural and metropolitan areas as the distinction between each is quite artificial. Additionally, the SAWG was concerned that limiting access to rural areas would not solve the issue of a lack of numbers, as rural centres may not have people available with the necessary skill base to assist with surgeries.

The SAWG also noted that non-medical surgical assisting was already occurring in metropolitan areas, as there is a lack of available medical surgical assistants after hours and on weekends. The SAWG considered that it was important to ensure all patients could access reimbursement and all credentialed non-medical surgical assistants have access to remuneration, regardless of where they lived or worked.

Cost-effectiveness and estimated cost to the government

Currently, if a patient agrees to have a qualified nurse as a surgical assistant, the surgical assistant fee is incurred as an out-of-pocket cost to the patient. Allowing non-medical surgical assistants access to MBS items will mean that patients are able to access reimbursement for this cost. However, because surgical assistants can set their own fees, if a nurse surgical assistant chooses to charge a fee above that of the MBS rebate, the excess will still be incurred as an out-of-pocket cost to patients, as is the case currently with medical surgical assistants.

The SAWG noted the statement from the ACNP that it is cost-effective to broaden MBS surgical assisting access, and ethically appropriate to ensure timely access to affordable health care. The SAWG also noted that, with equal patient outcomes and equal MBS patient rebates, the appropriately qualified non-medical surgical assistant is estimated to be as cost-effective as the medical surgical assistant. Furthermore, using a qualified non-medical surgical assistant saves time on training, which would equate to a cost saving and systems benefit.

The SAWG noted that the cost–benefit analysis should also consider the impacts of not broadening MBS access to include non-medical surgical assistants, which would include patients abandoning private health insurance, a reduction in surgical services, and extended waiting periods for surgery.

Qualitative and quantitative analysis

Strength of clinical evidence

The SAWG noted that there is growing evidence from high-income countries from the Organisation for Economic Co-operation and Development that NPs improve access to health care while promoting safe and quality outcomes. There is also a great body of Australian and international evidence in peer-reviewed journals relating to the benefits of the PNSA role in Australia specifically.

The SAWG noted that while the KPMG report did not specifically study surgical service, its discussion of private practice clinics supports this submission. The study found that the benefits of NPs vastly outweigh the costs, and it reported positive findings for quality of care and value of services. The report had a wide range of recommendations, consistent with those of the Nurse Practitioner Reference Group as part of the MBS Review, as well as numerous additional recommendations to government in relation to training and funding of positions.

Information gaps and barriers to implementation

Number of surgical assisting items being claimed

According to MBS usage data, the total number of 'Assist.' items billed in 2021–22 was 505,587, equating to $88,779,663 in benefits paid. The average out-of-pocket cost for patients was $301.98.

The SAWG noted that because most assisting item numbers do not match a particular surgical item number, it is difficult to determine the role surgical assistants are currently playing. The SAWG noted that while it is possible that an assistant was present for most surgeries, the data are lacking because the assistant cannot always claim the assisting item. The SAWG considered the discrepancy in the volume of surgeries and the proportion where an assistance item was also claimed, noting it is an indication of the extent to which these are filled by nurses or by other non-medical assistants, although it is currently unable to be accurately quantified.

Eligibility conditions

The SAWG considers that non-medical access to surgical assistance MBS items should be restricted to non-medical surgical assistants with appropriate credentials, training, and experience, including completion of an education qualification at Australian Qualifications Framework (AQF) level 8 as a PNSA.

The SAWG considered it important that eligibility is tied to programs of study that are accredited and then recognised by the relevant professional board. Without a formal accreditation process for an education program, the program can change core aspects (such as entry requirements, clinical exposure, or assessment mechanisms) without regulatory oversight.

The SAWG also considered that accreditation reliance on an NP program approved by the NMBA would mean that Services Australia would only have to verify the NP endorsement on the AHPRA register to confirm eligibility to claim.

Instead of relying on a PNSA-only qualification or solely on NP endorsement, the SAWG considered that, once appropriate credentialing has been endorsed and verified on the AHPRA register, the endorsement could then be used by the local hospital credentialing process, which is required by the National Safety and Quality Health Service Standards. The SAWG noted that Services Australia would need to use system coding to ensure that only non-medical surgical assistants with a PNSA qualification can claim the MBS items.

The SAWG considered that existing pathways can harmonise NP and PNSA education programs through recognition of prior learning, which would decrease the time and training needed to become qualified to assist and drive earlier growth in the surgical assistant workforce. The SAWG considered that this may only really benefit the private sector, but that this may still act to reduce pressure on the public sector.

However, the SAWG highlighted that surgical assistants are chosen based on a surgeon's preference, and surgeons will choose the surgical assistant most experienced and appropriate for the procedure – regardless of their level of clinical training.

Experienced nurses already working in the operating theatre would usually take on the role of non-medical surgical assistant.

Consultation and feedback review process

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Targeted consultation

In 2021, the Department of Health and Aged Care invited submissions from relevant peak bodies to inform an anticipated review of surgical assistant remuneration issues. Nine submissions were received.

Advice was sought and received from relevant areas within Department, including the Chief Nursing and Midwifery Officer and Health Workforce Division.

The SAWG final draft report was presented to the MRAC at its meeting on 5 August 2022. The MRAC provided further comments and endorsed the report for public consultation.

Public consultation

The SAWG final draft report was published on the Department of Health and Aged Care Consultation Hub for a six-week public consultation between 26 August 2022 and 7 October 2022.

The primary objective of this process was to test the robustness of the SAWG's findings and recommendations.

A total of 157 submissions was received during the consultation period. Submissions were received from relevant peak bodies and their individual members, as well as consumers and practicing physicians. Most submissions supported the recommendation to broaden access to MBS items to appropriately qualified non-medical surgical assistants.

The SAWG considered all feedback at its fourth meeting on 21 October 2022 and made its final recommendation.

Recommendations and actions

The SAWG recommends that a new set of MBS items be created that mirror current MBS items for surgical assistance (MBS items 51300 to 51318) and which can be claimed by appropriately qualified non-medical surgical assistants. The duplicate set of items should allow MBS claiming for suitably trained and experienced nurses and nurse practitioners registered with AHPRA. MBS eligibility should be coded to allow only appropriately trained and qualified non-medical surgical assistants to be able to claim the new items.

Descriptors for the new set of items will mirror the wording of descriptors of existing items 51300 to 51318, with the creation of an associated explanatory note outlining eligible providers. The following page presents explanatory notes for TN.9.1 – Assistance at Operations – (Items 51300 to 51318) and proposes new notes to be included with recommended new items for non-medical surgical assistants.

The SAWG recommends that the duplicate set of items be remunerated at the equivalent schedule fee of current MBS items 51300 to 51318, based on equivalence of service provided.

Changes are not recommended to have location-based requirements.

Current Explanatory Notes for TN.9.1

Assistance at Operations – (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule – Surgeon	**Multiple Operation Rule – Assistant**
Item A – $300@100%	Item A (Assist.) – $300@100%
Item B – $250@50%	Item B (No Assist.)
Item C – $200@25%	Item C (Assist.) – $200@50%
Item D – $150@25%	Item D (Assist.) – $150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently

Where two surgeons operate independently (i.e. neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

Related Items: 51300, 51303, 51306, 51309, 51312, 51315, 51318

Proposed new Explanatory Note (based on TN.9.1)

Assistance at Operations – (Items XXXX to XXXX)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a **suitably qualified nurse or nurse practitioner** other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

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The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently

Where two surgeons operate independently (i.e. neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

Related Items: XXXXX

Post-implementation review process

The Department of Health and Aged Care has developed a framework that guides post-implementation reviews (PIRs) of changes that have arisen from the MBS Review Taskforce and from MRAC recommendations. PIRs are used to determine if the changes have met their clinical intent and how the MBS items are being used in practice.

PIRs follow a three-step model:

- gather datasets
- analysis by the Department and prepare PIR report for review by the MRAC
- recommend and implement corrective actions, if necessary.

PIRs are usually conducted 24 months after implementation of a change, although some items may require more or less time to gather the necessary data to inform a robust review.

Any MBS items created or changed for surgical assisting will be subject to a PIR after they are implemented following a decision of Government.