

**Medicare Benefits Schedule
Review Advisory Committee**

Surgical Assistant Working Group

Draft Final Report

August 2022

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Summary

In Australia, surgeons can choose their own surgical assistant – someone who assists them during procedures. This is often someone that they trust and have a good working relationship with.

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. Sometimes, the only out-of-pocket costs to patients are for nurse surgical assistants.

Having to pay extra out-of-pocket costs for a non-medical surgical assistant, on top of other out-of-pocket fees associated with private services, means more patients choose to wait to have surgery in public hospitals. This not only puts more pressure on the public system, but can result in the patient's condition worsening 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 too much and, if so, what could be done to address it
- whether patients should be reimbursed when a surgeon chooses to use an experienced and qualified non-medical surgical assistant.

For the first issue, the SAWG could not find any evidence of surgical assistants charging patients too much for their services, so it did not recommend any changes to the current billing arrangements.

For the second issue, the SAWG recommended that patients should be reimbursed 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. The SAWG also considered that, because the surgeon chooses their surgical assistant, this would limit the number of non-medical surgical assistants accessing MBS items, so it would not be a significant extra cost to the government.

Acronyms

AANSA	Australian Association of Nurse Surgical Assistants
ACNP	Australian College of Nurse Practitioners
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHPRA	Australian Health Practitioner Regulation Agency
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
NPRG	Nurse Practitioner Reference Group
OECD	Organisation for Economic Co-operation and Development
PARC	Principles and Rules Committee
PASC	PICO Advisory Sub-Committee
PICO	population, intervention, comparator, outcomes
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) that the Australian Government subsidises. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapy, and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce, which from 2015 to 2020 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 MBS Review 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 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 is not appropriate;
- the safety and efficacy of existing MBS items; and
- implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC is comprised of multi-disciplinary and skills-based members including clinical, health systems and research experts, as well as allied health, nursing, and consumer representatives. The Committee's current members are:

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
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; and
 - 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 health care needs can be prioritised in design and implementation of MBS items.

The Committee notes that the MBS is one of several available approaches to the funding of health services.

Government consideration

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

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

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 (particularly in rural and remote areas), 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 former 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 Taskforce’s Principles and Rules Committee (PARC) considered the current arrangements for the remuneration of surgical assistants over a series of meetings, which commenced on 26 April 2016. PARC identified two main issues that result in patients paying varying 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 amount 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 objection from stakeholders of 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 reduction in assistant fees in a proportional sense. Consumers did not express a view on the proposal, despite it being designed primarily for their benefit.

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 increased out-of-pocket expenses for surgical assistance services rendered by a non-medical surgical assistant
- reduced access to surgical services in the private sector
- increased pressure from 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
- extended 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 (AANSA) applied to the Medical Services Advisory Committee (MSAC) seeking PNSA access to surgical assistance MBS items (MSAC Application 1359). The application, by Ms Lisa Yang (a representative of AANSA) and Ms Toni Hains, was presented to the December 2013 PICO Advisory Sub-Committee (PASC) meeting. Following this, the Department contacted the Nursing and Midwifery Board of Australia (NMBA), seeking their views and requesting information on the spread of medical surgical assistants and any gaps in servicing that may exist. Ultimately, the MSAC application was withdrawn.

In January 2019, Ms Hains submitted an initial MSAC application 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 is no health technology assessment question to answer.

Following the request from the Department for stakeholder submissions, Ms Hains 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

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.

In considering surgical assistant remuneration issues, the SAWG invited submissions from relevant organisations. Nine submissions were received.

The SAWG invited presentations from:

- Australian Association of Nurse Surgical Assistants (AANSA)
- Australian College of Nurse Practitioners (ACNP)
- Australian College of Nursing (ACN)
- Medical Surgical Assistants Society of Australia (MSASA)
- Royal Australian College of Surgeons (RACS)
- Dr Neil Meulman (independent surgeon).

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

SAWG findings

The SAWG considered that there were no significant data indicating instances where surgical assistants are charging a fee in excess of the primary surgeon. The SAWG considered the previous MBS Review 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 under 20%. **Therefore, the SAWG determined that the issue of surgical assistant billing arrangements will be closed, with no changes recommended.**

For 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 that patients can receive a rebate for means there is an inequity of access. Currently, nurses are providing up to 50% of surgical assisting and bill separately from the surgeon, and patients may be unwilling or unable to pay for nurse surgical assistants out of their own pocket. The SAWG noted that some surgeons completely bulk bill, particularly in rural areas, and the only out-of-pocket costs are for 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 surgeons, 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 a long 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, the more important factor is that it will reduce the out-of-pocket costs to patients and should facilitate a level of patient equity by expanding the choice of assistant.

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 GPs or medical interns. It also improves safety, which has been established through existing regulatory and credentialing

arrangements and 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 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-specialist 'service grade' medical graduates. However, the SAWG considered that the increase in medical surgical assistants is unlikely to happen quickly. The SAWG also considered that such an increase may not solve the issue, as given that choice of assistant is that of the surgeon, many may still prefer experienced nurses with whom they have a longstanding 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, titled *Cost benefit analysis of nurse practitioner models of care* and 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 that it would likely be cost neutral, although it may shift some nurses currently employed by hospitals or surgeons to Medicare billing.

The SAWG considered that the patient 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 from the ACNP 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 within the current model of care. The SAWG noted that it is important to consider the workforce that surgical assistants are being drawn from and what impact that 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 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 greater workforce of dedicated, well-trained surgical assistants. Decreasing the need for GPs to surgical assist may also allow procedural GPs in rural and remote areas to provide a better service to their community and complement 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 systems to avoid out-of-pocket costs, which would place more pressure on the public system. This could result in patients deteriorating while waiting 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.

Other issues

Qualifications and credentialling

The SAWG noted that there are differences in the educational regulatory governance between NPs with PNSA qualifications and people with PNSA qualifications alone. The SAWG noted that PNSA programs are not always accredited against recognised standards (see [Eligibility based on PNSA-only qualification](#)). Conversely, NPs are regulated specifically as an advanced practice nursing group and are underpinned by NP standards and educational standards; these include the Australian Commission on Safety and Quality in Health Care (ACSQHC) Clinical Governance Standards 1.23 and 1.24. The SAWG noted that these processes are monitored during each healthcare facility's accreditation audit. Further, many NP surgical assistants are accredited and credentialled 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 there is only one course for registered nurses wanting PNSA training, which is offered by La Trobe University. The SAWG noted that entry into the PNSA course requires a current registration with the Australian Health Practitioner Regulation Agency (AHPRA). The SAWG considered that using an AHPRA classification is in line with the approach used for medical practitioner eligibility to bill.

The SAWG noted that while surgical assistants are determined by formal credentialling processes, they 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 is an estimated 2,500 NPs in Australia, across all fields of practice. This number is steadily growing, believed to be the result of the Nurse Practitioner Steering Committee 10-year Plan and other initiatives. Comparatively, there are more than 400,000 nurses in Australia, and more than 300,000 registered nurses. The SAWG noted feedback from ACNP that funding PNSAs without an NP endorsement would need much greater consideration and would be a much bigger project to undertake. However, the SAWG considered that PNSAs with accreditation in surgical assisting should not be excluded from accessing MBS items.

The SAWG noted that while it is difficult to estimate the number of NP surgical assistants in Australia, it is approximated 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 Master's 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 that 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 an unmet need for medical surgical assistants after hours and on weekends. The SAWG considered that it was important to ensure all patients could be reimbursed and all credentialled 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 no longer incur 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 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.

The SAWG noted that the cost–benefit analysis should also consider the cost of not broadening MBS access for the non-medical surgical assistant, including patients abandoning private health insurance, a reduction in surgical services, and extended waiting periods for surgery. Furthermore, using a qualified non-medical surgical assistant saves time on training, which would equate to a cost saving and systems benefit.

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 (OECD) 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 about 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 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 (NPRG) 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

The SAWG notes that no consumer feedback has been sought or provided thus far to inform development of this report. Consumer feedback is considered valuable for informing discussion and the provision of final advice to government.

Consumer comments will specifically be sought during the consultation period.

Number of surgical assisting items being claimed

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 already playing. When looking at the number of claims for Caesarean section item numbers the previous financial year (which does have separate item numbers for surgery and assistant), it shows a large difference: 67,886 surgeries were claimed, compared to 21,782 assisting claims. The SAWG noted that while it is likely that an assistant was present for every surgery, the data are lacking because the item number cannot always apply to the assistant within the surgery. The SAWG questioned the discrepancy in the proportion of surgeries requiring assistance and the proportion where items are claimed, noting this needed to be managed somewhere – the extent to which these are filled by nurses or by other assistants.

Eligibility based on PNSA-only qualification

The SAWG noted that the PNSA program offered by La Trobe University is not accredited against recognised or professionally accepted standards. The SAWG considered that without a formal accreditation process for an education program, the program can change core aspects (such as entry requirements) without regulatory oversight. The SAWG considered it important that eligibility is tied to programs of study that are accredited and then recognised by the relevant professional board. Instead of relying on a PNSA-only qualification, the SAWG considered that existing pathways (such as some of La Trobe's Master's degree units) can harmonise NP and PNSA education programs through recognition of prior learning, which would decrease the time and training needed to become qualified to surgical assist and create earlier availability of the surgical assistant workforce. The SAWG considered that this may only really benefit the private sector, but that may reduce pressure on the public sector. The SAWG also considered that having an NP program approved by the NMBA would mean that Services Australia would only have to verify the NP endorsement on the AHPRA register. The PNSA (or equivalent) endorsement could then be relegated to the local hospital credentialing process, which is required by the ACSQHC.

Appropriate access of NPs to MBS items

The SAWG considers that NP access to surgical assistance MBS items should be restricted to NP with appropriate credentials, training, and experience. The SAWG noted that currently, the only regulatory classification of NPs is through NMBA endorsement, and this endorsement is agnostic of the type of NP.

Draft recommendations

The SAWG recommends that current MBS items for surgical assistants are altered to enable claiming by providers that are considered to be acceptable practitioners to perform the role.

This change should be achieved by updating explanatory note TN.9.1 (to Assistance at Operations – (Items 51300 to 51318)) to include a statement on what is an acceptable practitioner. This amendment would include add additional wording to the line within TN.9.1 which currently reads:

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

Proposed amendment as follows:

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

This would allow MBS claiming for suitably trained and experienced nurses and nurse practitioners. Eligibility to claim assistance at operations items for nurses and nurse practitioners will require completion of the Perioperative Nurse Surgical Assistant postgraduate qualification that has been recognised for Medicare provider number eligibility. The SAWG consider that this qualification requires minimum of 116 hours of study and appears to be the most reasonable credentialling pathway.

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 amended 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, or 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.

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.

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Multiple Operation Rule – Surgeon	Multiple Operation Rule – Assistant
Item A – \$300@100%	Item A (Assist.) – \$300@100%
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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: 51300, 51303, 51306, 51309, 51312, 51315, 51318