



**Australian Government**

**Department of Health**

# **Consultation Survey on MSAC Application 1597**

## **Cryoablation for small renal mass**

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

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

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

This feedback survey should take approximately 15 minutes to complete.

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

Thank you for taking the time to provide valuable feedback.

**Responses may be provided to the MSAC, its subcommittees, a health technology assessment group and the applicant. Should you require de-identification please contact the HTA team (details below).**

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

**Please reply to the HTA Team:**

**Email: [HTA@health.gov.au](mailto:HTA@health.gov.au)**

**Postal: MDP 959 GPO 9848 ACT 2601**

## PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

### 1. Respondent details

Name:

Email:

Phone No:

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

Individual

Collective Group

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

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

### 3. How would you best identify yourself?

General Practitioner

Specialist

Researcher

Consumer

Care giver

Other

**(a) If other, please specify**

## **PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE**

- 4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application form**

- 5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?**

- 6. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?**

- 7. What other benefits can you see from having this intervention publicly funded on the Medicare Benefits Schedule (MBS)?**

- 8. What other services do you believe need to be delivered before or after this intervention, eg Dietician, Pathology etc?**

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

9. Do you agree or disagree with the proposed population(s) for the proposed medical service as specified in Part 6a of the application form?

- Strongly Agree  
 Agree  
 Disagree  
 Strongly Disagree

(a) Specify why or why not:

10. Have all the associated interventions been adequately captured in Part 6b of the application form?

- Yes  
 No

(b) Please explain:

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

- Strongly Agree  
 Agree  
 Disagree  
 Strongly Disagree

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

- Strongly Agree  
 Agree  
 Disagree  
 Strongly Disagree

(a) Specify why or why not:

## PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. Do you agree with the proposed MBS item descriptor, as specified in Question 53 of the application form?

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

**(b) Specify why or why not:**

14. Do you agree or disagree with the proposed MBS fee, as specified in Question 53 of the application form?

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

**(c) Specify why or why not:**

## PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

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