



Dissolution of the Medicare Claims Review Panel and associated amendment to MCRP and plastic and reconstructive surgery items

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What are the changes?

From 1 November 2018, the Medicare Claims Review Panel (MCRP) will be dissolved and relevant items will be changed, to assist medical practitioners in understanding the appropriate use of items and to minimise misuse.

In addition, over 30 potentially cosmetic plastic surgery items will be amended to ensure consistency with the MCRP item changes, and to align them with appropriate clinical practice. Medicare does not fund cosmetic services.

Why are the changes being made?

The amendments are consistent with the MBS Review Taskforce's objectives of ensuring a contemporary MBS, with clearly written items retaining the clinical relevance test to which all MBS items are subject. More information about the Taskforce can be found on the [MBS Review Taskforce website](#).

What does this mean for providers?

Medical practitioners will no longer need to seek the MCRP's judgement on the clinical relevance of services they wish to perform under Medicare. This will reduce the administrative burden on providers.

What does this mean for patients?

Patients will hereafter have items processed in the same manner as the rest of the more than 5,700 items in the MBS. This will reduce the time it takes for patients to get rebates for these services.

When will this change be reviewed?

The Department of Health regularly reviews the usage of new and amended MBS items in consultation with the profession.

All MBS items may be subject to compliance processes and activities, including random and targeted audits which may require a provider to submit information about the services claimed.

Significant variation from forecasted expenditure may warrant review and amendment of fees, and incorrect use of MBS items can result in penalties including the health professional being asked to repay monies that have been incorrectly received.

Where can I find more information?

For information on the administrative arrangements for the MCRP, including if you have a current MCRP application, contact the Department of Human Services on 132 150.

Further information on other changes to the MBS can be found at the [MBS Online website](#).



New, amended and ceased items

(Draft wording of items to be finalised through regulatory amendments)

CATEGORY 2	
DI – Miscellaneous diagnostic procedures and investigations	
2 - Ophthalmology	
Overview	<ul style="list-style-type: none"> MBS items 11222 and 11225 for full quantitative computerised perimetry currently allow for additional examinations (where clinically relevant) within a 12 month period, and are currently subject to MCRP pre-approval. From 1 November, these items will be deleted, and the number of eligible examinations allowed under items 11221 and 11224 will be increased by one per year.
11221 Amended	<p>Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral—to a maximum of 3 examinations (including examinations to which item 11224 applies) in any 12 month period</p> <p>Fee: \$67.75 Benefit: 75% = \$50.85 85% = \$57.60</p>
11222 Ceased	<p>Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11221 applies due to presence of one of the following conditions:</p> <p>(a) established glaucoma (when surgery may be required within a 6 month period) if there has been definite progression of damage over a 12 month period;</p> <p>(b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient;</p> <p>(c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease;</p> <p>each additional examination</p> <p>Fee: \$67.75 Benefit: 75% = \$50.85 85% = \$57.60</p>
11224 Amended	<p>Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral—to a maximum of 3 examinations (including examinations to which item 11221 applies) in any 12</p>



	<p>month period</p> <p>Fee: \$40.85 Benefit: 75% = \$30.65 85% = \$34.75</p>
<p>11225 Ceased</p>	<p>Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions:</p> <p>(a) established glaucoma (when surgery may be required within a 6 month period) if there has been definite progression of damage over a 12 month period;</p> <p>(b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient;</p> <p>(c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease;</p> <p>each additional examination</p> <p>Fee: \$40.85 Benefit: 75% = \$30.65 85% = \$34.75</p>

<p>CATEGORY 2</p> <p>DI – Miscellaneous diagnostic procedures and investigations</p>	
<p>10 – Other diagnostic procedures and investigations</p>	
<p>Overview</p>	<ul style="list-style-type: none"> • A number of changes to diagnostic procedures for thoracic items are being made as a result of recommendations from the MBS Taskforce Review of Thoracic Medicine. Further information on the full suite of changes to Thoracic Medicine items can be accessed via the MBS online factsheet. • Item 12207 is for an additional lab based sleep study for patients over 18 years of age, where a further investigation in the same 12 month period to which items 12204 and 12205 applies. • Item 12215 is a lab-based investigation for a patient aged 0 - 12 years, where a further investigation to which item 12210 applies, is required in the same 12 month period. • Item 12217 is for additional lab-based investigation/s for a patient aged 12 - 18 years, where a further investigation under 12213 is required in the same 12 month period. • From 1 November 2018, the MCRP pre-approval requirement for 12207; 12215; and 12217 will be removed.
<p>12207 Amended</p>	<p>Overnight investigation, for a patient aged 18 years or more, for a sleep-related breathing disorder, following professional attendance by a qualified sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p>



	<p>(c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:</p> <ul style="list-style-type: none"> (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen) (ix) position; and <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <ul style="list-style-type: none"> (i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and <p>(f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient; and</p> <p>(h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and</p> <p>(i) if the patient has severe cardio-respiratory failure—a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep</p> <p>Applicable only once in the same 12 month period to which item 12204 or 12205 applies</p> <p>Fee: \$588.00 Benefit: 75% = \$441.00 85% = \$506.30</p>
<p>12215 Amended</p>	<p>Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient less than 12 years of age, if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: <ul style="list-style-type: none"> (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation;



	<p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p>(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of report; and</p> <p>(f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and</p> <p>(g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances:</p> <p>(i) there is ongoing hypoxia or hypoventilation on the third study to which item 12210 applied for the patient, and further titration of respiratory support is needed to optimise therapy;</p> <p>(ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support</p> <p>Applicable only once in the same 12 month period to which item 12210 applies</p> <p>Fee: \$701.85 Benefit: 75% = \$526.40 85% = \$620.15</p>
<p>12217 Amended</p>	<p>Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged at least 12 years but less than 18 years, if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:</p> <p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p>



	<p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p>(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of report; and</p> <p>(f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and</p> <p>(g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances:</p> <p>(i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy;</p> <p>(ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support</p> <p>Applicable only once in the same 12 month period to which item 12213 applies</p> <p>Fee: \$632.30 Benefit: 75% = \$474.25 85% = \$550.60</p>
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CATEGORY 3	
T10 – Anaesthesia performed in connection with certain services (Relative Value Guide)	
Overview	<ul style="list-style-type: none"> From 1 November, the MCRP pre-approval requirement for item 21965 and item 21997 will be removed.
17 – Anaesthesia for radiological or other diagnostic or therapeutic procedures	
21965 Amended	<p>Initiation of the management of anaesthesia as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology</p> <p>Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15</p>
18 – Miscellaneous	
21997 Amended	<p>Initiation of the management of anaesthesia in connection with a procedure covered by an item that does not include the word “(Anaes.)”, other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia</p> <p>Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35</p>



CATEGORY 3	
T8 – Surgical Operations	
1 – General	
Overview	<ul style="list-style-type: none"> A number of changes to general surgical operations will be made to remove the MCRP pre-approval requirements, and delete items that are no longer considered best clinical practice. Item 30176 has been amended to clarify that patients who have previously had a massive intra-abdominal or pelvic tumour surgically removed are eligible to claim this item.
30176 Amended	<p>Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.)</p> <p>Fee: \$985.70 Benefit: 75% = \$739.30</p>
30214 Ceased	<p>Telangiectases or starburst vessels on the head or neck if lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation-session of at least 20 minutes in duration—if it can be demonstrated that a seventh or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</p> <p>Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35</p>
31346 Amended	<p>Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if:</p> <p>(a) the lesion is subcutaneous; and (b) the lesion is 50 mm or more in diameter; and (c) photographic and/or diagnostic imaging evidence demonstrating the need for this service must be included in patient notes</p> <p>(Anaes.)</p> <p>Fee: \$985.70 Benefit: 75% = \$739.30</p>
32501 Ceased	<p>Varicose veins if varicosity measures 2.5 mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation—one or both legs—other than a service associated with another varicose vein operation on the same leg (excluding after-care)—if it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination and that a seventh or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period</p> <p>Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35</p>



CATEGORY 3	
T8 – Surgical operations	
4 – Gynaecological	
Overview	<ul style="list-style-type: none"> From 1 November, the MCRP pre-approval requirement for item 35534 will be removed. Item 35534 will be amended to specify that the procedure must only be performed by specialists on patients who are 18 years of year or over. Detailed clinical notes on the structural abnormality demonstrating the need for the service must be included in the patient notes.
35533 Amended	<p>Vulvoplasty or labioplasty, for repair of:</p> <p>(a) female genital mutilation; or</p> <p>(b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract</p> <p>other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (H) (Anaes.)</p> <p>Fee: \$349.85 Benefit: 75% = \$262.40</p>
35534 Amended	<p>Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist’s specialty, for a structural abnormality that is causing significant functional impairment, if the patient’s labium extends more than 8 cm below the vaginal introitus while the patient is in a standing resting position (H) (Anaes.)</p> <p>Fee: \$349.85 Benefit: 75% = \$262.40</p>

CATEGORY 3	
DI – Miscellaneous diagnostic procedures and investigations	
9 – Ophthalmology	
Overview	<ul style="list-style-type: none"> Former MCRP items for laser trabeculoplasty (42783), laser iridotomy (42786), laser capsulotomy (42789), and laser vitreolysis or corticolysis of lens material or fibrinolysis (42792) will be removed from the MBS, with additional treatments allowed under items 42785 and 42789 in a 2 year period.
42783 Ceased	<p>Laser trabeculoplasty, for the treatment of glaucoma—each treatment to one eye— if it can be demonstrated that a fifth or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period (Anaes.) (Assist.)</p> <p>Fee: \$451.10 Benefit: 75% = \$338.35 85% = \$383.45</p>
42785 Amended	<p>Laser iridotomy—each treatment episode to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)</p> <p>Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35</p>



42786 Ceased	Laser iridotomy—each treatment episode to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period (Anaes.) (Assist.) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35
42789 Ceased	Laser capsulotomy—each treatment episode to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period—other than a service associated with a service to which item 42702 applies (Anaes.) (Assist.) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35
42791 Amended	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity—each treatment to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35
42792 Ceased	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity—each treatment to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period (Anaes.) (Assist.) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35
42872 Amended	Eyebrow, elevation of, by skin excision, to correct for a reduced field of vision caused by parietic, involuntal, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.) Fee: \$240.70 Benefit: 75% = \$180.55 85% = \$204.60

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery	
Overview	<ul style="list-style-type: none"> From 1 November, the MCRP pre-approval requirement for items 45019 will be removed. Item 45019 will be amended to specify it must be performed by specialist dermatologists or plastic surgeons and only one treatment should be performed in any 12 month period. Item 45020 will be removed as it is obsolete. The MCRP pre-approval requirement for item 45051 will be removed. It is expected that patient records will include photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service.
45019 Amended	Full face chemical peel for severely sun-damaged skin, if: <ol style="list-style-type: none"> the damage affects at least 75% of the facial skin surface area; and the damage involves photo-damage (dermatoheliosis); and the photo-damage involves:



	<p>(i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigines; or (iii) freckling, yellowing or leatherying of the skin; or (iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and (d) at least medium depth peeling agents are used; and (e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the speciality of dermatology or plastic surgery.</p> <p>Applicable once only in any 12 month period (H) (Anaes.) Fee: \$396.70 Benefit: 75% = \$297.55</p>
45020 Ceased	<p>Full face chemical peel for severe chloasma or melasma refractory to all other treatments, if it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres, when at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her speciality— one session only in a 12 month period (H) (Anaes.)</p>
45051 Amended	<p>Contour reconstruction by open repair of contour defects, due to deformity, if:</p> <p>(a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(H) (Anaes.) (Assist.) Fee: \$473.75 Benefit: 75% = \$355.35</p>

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery - BREAST PROCEDURES	
Overview	<ul style="list-style-type: none"> Three new items (45060, 45061 and 45062) will be introduced to replace item 45559 for treatment of developmental breast abnormality. The items will more accurately reflect current clinical practice, including allowing for two stage procedures.
45060 New item	<p>Developmental breast abnormality, single stage correction of, if:</p> <p>(a) the correction involves either: (i) bilateral mastopexy for symmetrical tubular breasts; or</p>



	<p>(ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammoplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and</p> <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)</p> <p>Fee: \$1,271.30 Benefit: 75% = \$953.50</p>
45061 New item	<p>Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammoplasty, if:</p> <p>(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:</p> <ul style="list-style-type: none">(i) 20% in normally shaped breasts; or(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.</p> <p>Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)</p> <p>Fee: \$1,271.30 Benefit: 75% = \$953.50</p>
45062 New item	<p>Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammoplasty, if:</p> <p>(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:</p> <ul style="list-style-type: none">(i) 20% in normally shaped breasts; or(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.</p> <p>Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)</p> <p>Fee: \$920.00 Benefit: 75% = \$690.00</p>

CATEGORY 3

T8 – Surgical operations



13 – Plastic and Reconstructive Surgery - BREAST PROCEDURES CONT.	
Overview	<ul style="list-style-type: none">Item 45523 will be introduced for bilateral breast reduction procedures for patients with macromastia. Item 45520 will be amended to specify it should be used in the context of breast cancer or developmental abnormality of the breast.Item 45524 for unilateral augmentation mammoplasty will be amended to specify it should be used only in the context of breast cancer or in the context of developmental breast abnormality where there is a demonstrated difference in breast volume.Item 45527 will be amended to clarify that it is for breast reconstruction.The MCRP pre-approval requirement for item 45528 will be removed. It is expected that patient records will include photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service.
45520 Amended	Reduction mammoplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (H) (Anaes.) (Assist.) Fee: \$900.45 Benefit: 75% = \$675.35
45522 Amended	Reduction mammoplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (H) (Anaes.) (Assist.) Fee: \$631.75 Benefit: 75% = \$473.85
45523 New item	Reduction mammoplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia and experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis (H) (Anaes.) (Assist.) Fee: \$1,350.70 Benefit: 75% = \$1013.05
45524 Amended	Mammoplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)
45527 Amended	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (H) (Anaes.) (Assist.)
45528	Mammoplasty, augmentation, bilateral (other than a service to which item 45527 applies), if:



Amended	<p>(a) reconstructive surgery is indicated because of:</p> <ul style="list-style-type: none"> (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(H) (Anaes.) (Assist.)</p>
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CATEGORY 3
T8 – Surgical operations

13 – Plastic and Reconstructive Surgery - BREAST PROCEDURES CONT.

Overview	<ul style="list-style-type: none"> • Item 45552 will be removed and Item 45551 will be amended to clarify benefits will be payable where at least half the fibrous capsule is removed and confirmed by histopathology. • Where patients are experiencing medical complications, such as the rupture, migration of prosthetic material or symptomatic capsular contracture, MBS items for the removal and replacement of the prosthesis are available under items 45553 and 45554 if: <ul style="list-style-type: none"> - it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or - the original implant was inserted in the context of breast cancer or developmental abnormality. • It is expected that patient records will include photographic and / or diagnostic evidence demonstrating the clinical need for these services. • The schedule fee for Item 45553 will be revised to \$571.60.
45551 Amended	<p>Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (H) (Anaes.) (Assist.)</p> <p>Fee: \$443.70 Benefit: 75% = \$332.80</p>
45552 Ceased	<p>Breast prosthesis, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.)</p>
45553 Amended	<p>Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if:</p> <p>(a) either:</p> <ul style="list-style-type: none"> (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical</p>



	<p>need for this service is documented in the patient notes (H) (Anaes.) (Assist.) Fee: \$571.60 Benefit: 75% = \$428.70</p>
45554 Amended	<p>Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if:</p> <p>(a) either:</p> <p>(i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or</p> <p>(ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and</p> <p>(b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and</p> <p>(c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(H) (Anaes.) (Assist.) Fee: \$699.45 Benefit: 75% = \$524.60</p>
45555 Ceased	<p>Silicone breast prosthesis, removal of and replacement with prosthesis other than silicone gel prosthesis (H) (Anaes.) (Assist.) Fee: \$638.65 Benefit: 75% = \$479.00</p>

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery - BREAST PROCEDURES CONT.	
Overview	<ul style="list-style-type: none"> From 1 November, the MCRP pre-approval requirement for items 45556 and 45558 will be removed. It is expected that patient records will include photographic and/or diagnostic evidence demonstrating the clinical need for these services. Item 45557 will be removed. Item 45559 will be removed and replaced with three new items (45060, 45061 and 45062).
45556 Amended	<p>Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.) Fee: \$766.05 Benefit: 75% = \$574.55</p>
45557 Ceased	<p>Breast ptosis, correction by mastopexy of (unilateral), following pregnancy and lactation, when performed not less than one year, and not more than 7 years, after the end of the most recent pregnancy of the patient, and if it can be demonstrated that the nipple is inferior to the infra-mammary groove, other than a service</p>



	<p>associated with a service to which item 45522 applies (H) (Anaes.) (Assist.) Fee: \$766.05 Benefit: 75% = \$574.55</p>
<p>45558 Amended</p>	<p>Breast ptosis, correction by mastopexy of (bilateral), if:</p> <ul style="list-style-type: none"> (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and (c) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes <p>Applicable only once per lifetime (H) (Anaes.) (Assist.) Fee: \$1,148.95 Benefit: 75% = \$861.75</p>
<p>45559 Ceased</p>	<p>Tuberous, tubular or constricted breast, if it can be demonstrated, correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.) Fee: \$1,136.80 Benefit: 75% = \$852.60 85% = \$1053.40</p>

<p>CATEGORY 3</p> <p>T8 – Surgical operations</p>	
<p>13 – Plastic and Reconstructive Surgery – LIPOSUCTION</p>	
<p>Overview</p>	<ul style="list-style-type: none"> • Liposuction item 45586 will be deleted and combined with item 45585 for the treatment of Barraquer-Simons Syndrome, lymphoedema, macrodystrophia lipomatosa or the reduction of buffalo hump where it is secondary to an endocrine disorder or pharmacological treatment of a medical condition. Benefits are payable for liposuction of one regional area which is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.
<p>45584 Amended</p>	<p>Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post-traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) Fee: \$631.75 Benefit: 75% = \$473.85</p>
<p>45585 Amended</p>	<p>Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), other than a service associated with a service to which item 31525 applies, if:</p> <ul style="list-style-type: none"> (a) the liposuction is for: <ul style="list-style-type: none"> (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes <p>(H) (Anaes.)</p>



	Fee: \$631.75 Benefit: 75% = \$473.85
45586 Ceased	Liposuction (suction assisted lipolysis) for reduction of a buffalo hump, if it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition (H) (Anaes.) Fee: \$631.75 Benefit: 75% = \$473.85

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery - MELOPLASTY	
Overview	<ul style="list-style-type: none"> Item 45587 for unilateral meloplasty will be amended to clarify that facial asymmetry be secondary to trauma, a congenital condition or other medical conditions such as facial nerve palsy. Benefits are limited to procedures performed in hospital. Benefits for bilateral meloplasty under item 45588 will be payable where the surgery corrects a functional impairment caused by a congenital condition, disease, or trauma. The amendments restrict the payment of benefits for the correction of acne scarring to help prevent cosmetic misuse.
45587 Amended	Meloplasty for correction of facial asymmetry if: (a) the asymmetry is secondary to trauma (including previous surgery), a congenital condition or a medical condition (such as facial nerve palsy); and (b) the meloplasty is limited to one side of the face (H) (Anaes.) (Assist.) Fee: \$890.85 Benefit: 75% = \$668.15
45588 Amended	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if: (a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.) Fee: \$1,336.40 Benefit: 75% = \$1,002.30

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery	
Overview	<ul style="list-style-type: none"> Item 45617 will be amended to specify that where the indication for surgery is skin redundancy causing a visual field defect, this is to be confirmed by an optometrist or ophthalmologist. It is expected that patient records will include photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service.



45617 Amended	<p>Upper eyelid, reduction of, if:</p> <p>(a) the reduction is for any of the following:</p> <ul style="list-style-type: none">(i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid;(ii) herniation of orbital fat in exophthalmos;(iii) facial nerve palsy;(iv) post-traumatic scarring;(v) the restoration of symmetry of the contralateral upper eyelid in respect of one of these conditions; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(Anaes.)</p> <p>Fee: \$235.05 Benefit: 75% = \$176.30 85% = \$199.80</p> <p>Extended Medicare Safety Net Cap: \$188.05</p>
45620 Amended	<p>Lower eyelid, reduction of, if:</p> <p>(a) the reduction is for:</p> <ul style="list-style-type: none">(i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or(ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and <p>(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(Anaes.)</p> <p>Fee: \$326.05 Benefit: 75% = \$244.55 85% = \$277.15</p> <p>Extended Medicare Safety Net Cap: \$260.85</p>
45623 Amended	<p>Ptosis of upper eyelid (unilateral), correction of, by:</p> <p>(a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or</p> <p>(b) sutured suspension to the brow/frontalis muscle;</p> <p>Not applicable to a service for repair of mechanical ptosis to which item 45617 applies</p> <p>(Anaes.) (Assist.)</p> <p>Fee: \$723.05 Benefit: 75% = \$542.30 85% = \$639.65</p> <p>Extended Medicare Safety Net Cap: \$578.45</p>
45624 Amended	<p>Ptosis of upper eyelid, correction of, by:</p> <p>(a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or</p> <p>(b) sutured suspension to the brow/frontalis muscle;</p> <p>if a previous ptosis surgery has been performed on that side</p> <p>(Anaes.) (Assist.)</p> <p>Fee: \$937.40 Benefit: 75% = \$703.05 85% = \$854.00</p> <p>Extended Medicare Safety Net Cap: \$749.95</p>



CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery - RHINOPLASTY	
Overview	<ul style="list-style-type: none"> Rhinoplasty items 45632 to 45644 and 45650 have been consolidated and amended to ensure consistency and clarify that rebates are available where the indication for surgery is: <ol style="list-style-type: none"> Airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or Significant acquired, congenital or developmental deformity. The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2. The NOSE Scale can be accessed on the American Academy of Otolaryngology Health and Neck Surgery website. It is expected that the clinical details are retained in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service. The schedule fee for item 45641 has been revised to \$1,066.00 and limited to in-hospital.
45632 Amended	<p>Rhinoplasty, partial, involving correction of lateral or alar cartilages, if:</p> <p>(a) the indication for surgery is:</p> <ol style="list-style-type: none"> airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or significant acquired, congenital or developmental deformity; and <p>(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(Anaes.)</p> <p>Fee: \$511.95 Benefit: 75% = \$384.00 85% = \$435.20</p> <p>Extended Medicare Safety Net Cap: \$409.60</p>
45635 Amended	<p>Rhinoplasty, partial, involving correction of bony vault only, if:</p> <p>(a) the indication for surgery is:</p> <ol style="list-style-type: none"> airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or significant acquired, congenital or developmental deformity; and <p>(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(Anaes.)</p> <p>Fee: \$587.60 Benefit: 75% = \$440.70 85% = \$504.20</p> <p>Extended Medicare Safety Net Cap: \$470.10</p>
45638 Ceased	<p>Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (H)</p> <p>(Anaes.)</p> <p>Fee: \$1,014.05 Benefit: 75% = \$760.55</p>



45639 Ceased	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, if it can be demonstrated that there is a need for correction of significant developmental deformity (H) (Anaes.) Fee: \$1,014.05 Benefit: 75% = \$760.55
45641 Amended	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) Fee: \$1,066.00 Benefit: 75% = \$799.50
45644 Amended	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.) Fee: \$1,279.45 Benefit: 75% = \$959.60
45650 Amended	Rhinoplasty, revision of, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) Fee: \$147.80 Benefit: 75% = \$110.85 85% = \$125.65

CATEGORY 3	
T8 – Surgical operations	
13 – Plastic and Reconstructive Surgery - CONGENITAL DEFORMITIES OF THE EAR	
Overview	<ul style="list-style-type: none"> The correction of congenital deformities of the ear, such as 'bat ear', will be amended to clarify the clinical indications for the procedure, limited to in-hospital only procedures and restricted to patients less than 18 years of age to help prevent cosmetic misuse.
45659 Amended	Correction of a congenital deformity of the ear if: (a) the patient is less than 18 years of age; and (b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and



	<p>(c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes</p> <p>(H) (Anaes.) (Assist.)</p> <p>Fee: \$521.25 Benefit: 75% = \$390.95</p>
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