Medicare Benefits Schedule Review Taskforce

Report from the Plastic and Reconstructive Surgery Clinical Committee

Important note

The views and recommendations in this report from the Clinical Committee have been released for the purpose of seeking the views of stakeholders.

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

- Stakeholder feedback.

Then

- Consideration by the MBS Review Taskforce.

Then, *if endorsed*, consideration by

- The Minister for Health.
- The Government.

Stakeholders should provide comment on the recommendations via mbsreviews@health.gov.au.

Confidentiality of comments:

If you would like your feedback to remain confidential, please mark it as such. It is important to be aware that confidential feedback may still be subject to access under freedom of information law.

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1. Executive summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a programme of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

The Plastic and Reconstructive Surgery Clinical Committee (the Committee) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The recommendations from the clinical committees are released for stakeholder consultation. The clinical committees consider feedback from stakeholders then provide recommendations to the Taskforce in a review report. The Taskforce considers the review reports from clinical committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

1.1 Key recommendations

Of the 288 items in scope, the Committee has made 61 recommendations to modernise the MBS and ensure the items and fees reflect contemporary practice. These recommendations include amending 109 item descriptors and/or fees, deleting 98 items and creating 81 new items. If all of these recommendations are implemented it would result in a total of 271 items in this section of the MBS.

- **Creation of new items for conjoint surgery and items specific to bilateral procedures**

The Committee recommends facilitating the practice of surgeons working together in burns surgery and creating conjoint surgical items for complex microsurgical breast reconstruction and complex microsurgical reconstruction of the head and neck and osteotomies of the mandible and maxilla. These recommendations are in line with current best practice where conjoint surgery reduces operating times and improves patient outcomes.

The Committee also recommends generation of bilateral item numbers where paired structures are involved (e.g. breasts) to be in line with the concept of the complete medical service.

- **Restructuring of general and skin items for consistency throughout the MBS**

The Committee recommends general and skin items be amended to align with the previous skin services review. This will enable a clear and rational provision of services for excision and repair of skin and sub-cutaneous lesions, which is of particular importance to the Australian community where the prevalence of skin cancer is high and the need for these services significant. The Committee recommends reviewing and increasing remuneration in this area so that provision of this valuable service is financially viable for procedural General Practitioners (GP) and surgeons in the setting of their rooms.

- **Complete restructure of burns items**

The Committee considered the current burns items to be out of date and inconsistent with current clinical practice and therefore recommends a complete restructure of these items. This restructure will simplify the Schedule and take into account improvements that have occurred in this field. The two most major factors are the introduction of skin substitutes as standard practice and the practice of having more than one burns surgeon operating on one patient, so as to reduce the duration of surgery. The Committee recommends that burns items should be organised into clear tables, which take into account the excision of the burn and either immediate or delayed closure, with specific and clear rules regarding co-claiming of these items. This approach is rational, modern and predictable for patients and their families.

- **Reorganised breast cancer and reconstruction items**

The Committee recommends that breast cancer items be reorganised to reflect modern breast cancer surgery, especially in regards to lymph node surgery and skin sparing and

nipple-sparing mastectomy procedures. The Committee recommends new items specifically for post-mastectomy breast reconstruction, rather than the existing situation where providers are using a variety of general autologous flap items not specifically for breast reconstruction. The driver for generating items specific to post-mastectomy breast reconstruction is to minimise ambiguity regarding appropriate claiming of items, which will enable patients undergoing mastectomy to have better predictability of billing patterns. In addition, Australia is one of the few developed nations unable to report post-mastectomy breast reconstruction rates with any accuracy because of the overlap of coding with other reconstructive procedures. Inclusion of dedicated breast reconstruction items would give the Australian government a picture of the rates of reconstruction, where the unmet need is and how Australia compares to the international community.

- **Reorganised Cranio-Maxillofacial/Oral and Maxillofacial Items**

The Committee has made many recommendations in this section to rationalise and update items to be consistent with modern best practice. This includes updating terminology, deleting obsolete items and harmonising both the cranio-maxillofacial and oral and maxillofacial items. This recommendation will enable predictability for patients and a robust, fit for purpose Schedule for providers of care in this field.

- **Update terminology of the paediatric plastic surgery items**

The Committee recommends updating the terminology of this section to be consistent with international classifications and contemporary understanding in the field.

- **Safeguarding Medicare against inappropriate cosmetic use**

The Committee has made recommendations to multiple items to specifically restrict use for cosmetic purposes and suggests that Medicare should continue to be aware of the risk of inappropriate use of items for the purposes of cosmetic surgery into the future. Further to this the Committee recommends that the Department of Health considers launching a project to investigate the human and financial costs of poor body image within the community and investigate whether a public health project would be beneficial in this space.

1.2 Consumer impact

All recommendations have been summarised for consumers in Appendix A – Summary for consumers. The summary describes the medical service, the recommendation of the clinical experts and the rationale behind the recommendations. A consumer impact statement is available in Section 10.

The Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations—and how and why. Following targeted consultation, the Committee will assess the advice from consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendations to Government.

Both patients and clinicians are expected to benefit from these recommendations because they address concerns regarding patient safety and quality of care, and because they take steps to simplify the MBS and make it easier to use and understand. In addition, the Committee's recommendations promote the provision of higher value medical care, which can reduce unnecessary procedures and related out-of-pocket fees for patients, while supporting improved access to modern procedures and the responsible operation of the healthcare system as a whole.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme. It enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items, which provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review is clinician-led, and there are no targets for savings attached to the review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist

workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.

- Best practice health services—one of the core objectives of the MBS Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- Value for the individual patient—another core objective of the MBS Review is to support the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- Value for the health system—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria (1). The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value,[1] are misused[2] and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2" or "priority 3", using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or Colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise the review report, which provides recommendations for the Taskforce.

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of the review and its timeframe, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

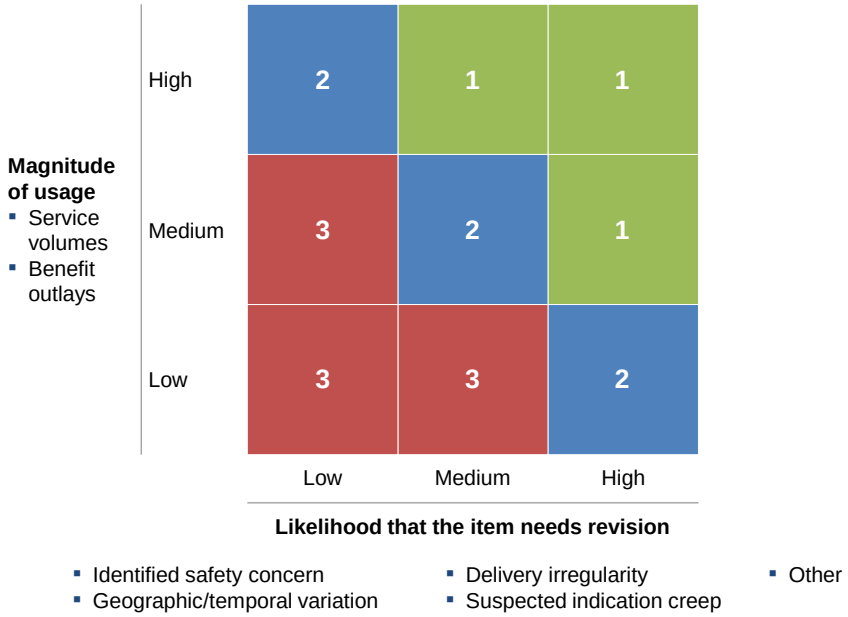
- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery

[1] The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

[2] The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.

irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).

Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

2.5 Complete Medical Service Concept

The Taskforce has recommended that each MBS item in the surgical section (T8) of the MBS represents a complete medical service and highlighted that it is not appropriate to claim additional items in relation to a procedure that are intrinsic to the performance of that procedure.

It is proposed that for surgical procedures, this principle will be implemented through restricting claiming to a maximum of three MBS surgical items for a single procedure or episode of care. For bilateral procedures benefits will be paid for a maximum of six surgical items for an episode of care. The existing multiple operation rule will be applied to these items.

The Taskforce's rationale for making this recommendation is that 94 per cent of MBS benefits paid are for episodes where three or fewer items are claimed. On the occasions when more than three items are claimed in a single procedure or episode of care, there is often less transparency and greater inter-provider variability in benefits claimed for the same services, greater out-of-pocket expenditure for patients, and increased MBS expenditure that does not necessarily result in improved patient care.

Where the same group of three or more items are consistently co-claimed across providers, these represent a complete medical service and should be consolidated. Consolidation will improve consistency and optimise the quality of patient care; reduce unnecessary out-of-pocket costs for patients; and better correlate MBS expenditures with the actual services provided to patients. The PRSCC recognises that there will still be cases where it may not be possible to accurately describe a patient's episode of care within three items, particularly for complex digital replantations, microvascular head and neck surgery and other complex reconstructive cases.

3. About the Plastic and Reconstructive Surgery Clinical Committee

The Committee was established in June 2018 to make recommendations to the Taskforce on MBS items within its remit, based on rapid evidence review and clinical expertise.

3.1 Plastic and Reconstructive Surgery Clinical Committee members

The Committee consists of 15 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Plastic and Reconstructive Surgery Clinical Committee Members

Name	Position/organisation	Declared conflict of interest
Dr Nicola Dean	Plastic and Reconstructive Surgeon in private/public practice in Adelaide Head of Plastic and Reconstructive Surgery Services at Flinders Medical Centre Honorary Secretary of the Council of the Australian Society of Plastic Surgeons Member of MBS Review Breast Cancer Surgery and Reconstruction Working Group	Claims in-scope MBS items
A/Prof Hugh Bartholomeusz	Plastic and Reconstructive Surgeon in private/veterans affairs practice Former Head of the Plastic Surgery Unit at Greenslopes Private Hospital Former President of the Council of the Australian Society of Plastic Surgeons	Claims in-scope MBS items
Prof Michael Besser	Consultant Emeritus Neurosurgeon, Sydney Lecturer in neuroanatomy at University of Sydney Member of the MBS Review Taskforce	None
Dr Heather Cleland	Director of Plastic and Maxillofacial Surgery, Royal Children's Hospital, Melbourne	Claims in-scope MBS items

Name	Position/organisation	Declared conflict of interest
	Director of Victorian Adult Burns Service, The Alfred Hospital, Melbourne	
A/Prof Elisabeth Elder	Specialist Breast Surgeon in private/public practice in Sydney Clinical Associate Professor at University of Sydney Chair of the Oncoplastic Committee, BreastSurgANZ. Consultant Surgeon at Westmead Breast Cancer Institute Council Member of Breast Surgeons International Chair of MBS Review Breast Cancer Surgery and Reconstruction Working Group.	Claims in-scope MBS items Holds shares in a private hospital
Dr Matthew Hawthorne	Oral and Maxillofacial Surgeon in private/public practice in Brisbane Chair of the Accreditation Committee for the Australia and New Zealand OMS training programs	Claims in-scope MBS items
Ms Chris Horsell	Board Director, Reclaim Your Curves Member of MBS Review Breast Cancer Surgery and Reconstruction Working Group	None
Dr Dan Kennedy	Plastic and Reconstructive Surgeon in private/public practice in Brisbane Consultant Plastic Surgeon at Mater Adults Hospital Honorary Treasurer of the Australian Society of Plastic Surgeons Member of the Australiasian Society of Aesthetic Plastic Surgeons and the International Society of Aesthetic Plastic Surgeons. Member of MBS Review Breast Cancer Surgery and Reconstruction Working Group	Claims in-scope MBS items Clinical trainer and educator for Galderma Australia Pty. Ltd Holds shares in a private hospital
Dr Tim Manners	GP, Kings Park Clinic and Flinders Medical Centre	Claims in-scope MBS items

Name	Position/organisation	Declared conflict of interest
Mr Mark Moore	Plastic and Reconstructive Surgeon in private/public practice in Adelaide Medical Unit Head, Australian Craniofacial Unit, Women's and Children's Hospital, Adelaide	Claims in-scope MBS items
Ms Jill Rowbotham	Former Breast Cancer Network Australia (BCNA) State Development Manager (NSW)	None
Dr Paul Sambrook	Head of Discipline, Oral and Maxillofacial Surgery (OMS), Faculty of Health Sciences, The University of Adelaide Head of Unit Oral Maxillofacial Surgery at the Royal Adelaide Hospital and South Australian Dental Service Royal Australasian College of Dental Surgeons Vice President of the International Board for the Certificate of Specialists in OMS Former President of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons Director of Training for oral and maxillofacial surgery for South Australia	Claims in-scope MBS items
Dr Patricia Terrill	Plastic and Reconstructive Surgeon private/public practice in Melbourne Head of the Plastic and Reconstructive Unit at Peninsula Health (Frankston Hospital)	Claims in-scope MBS items
Mr Tut Gordon Tut	Solicitor, Victoria Legal Aid	None
Dr John Vandervord	Plastic and Reconstructive Surgeon in private/public practice in Sydney Specialist in Maxillofacial Burns and Paediatric Surgery.	Claims in-scope MBS items

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their

declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1.

It is noted that the majority of the Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Committee members claim the items under review). This conflict is inherent in a clinician-led process and, having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3.3 Areas of responsibility of the Committee

The Committee reviewed 288 MBS items.

In financial year (FY) 2016/17, these items accounted for approximately 198,000 services and $58 million in benefits. Over the past five years, service volumes for these items have grown at 5.3 per cent per year, and the cost of benefits has increased by 5.0 per cent per year. This growth is largely explained by an increase in the number of services per capita (Figure 2).

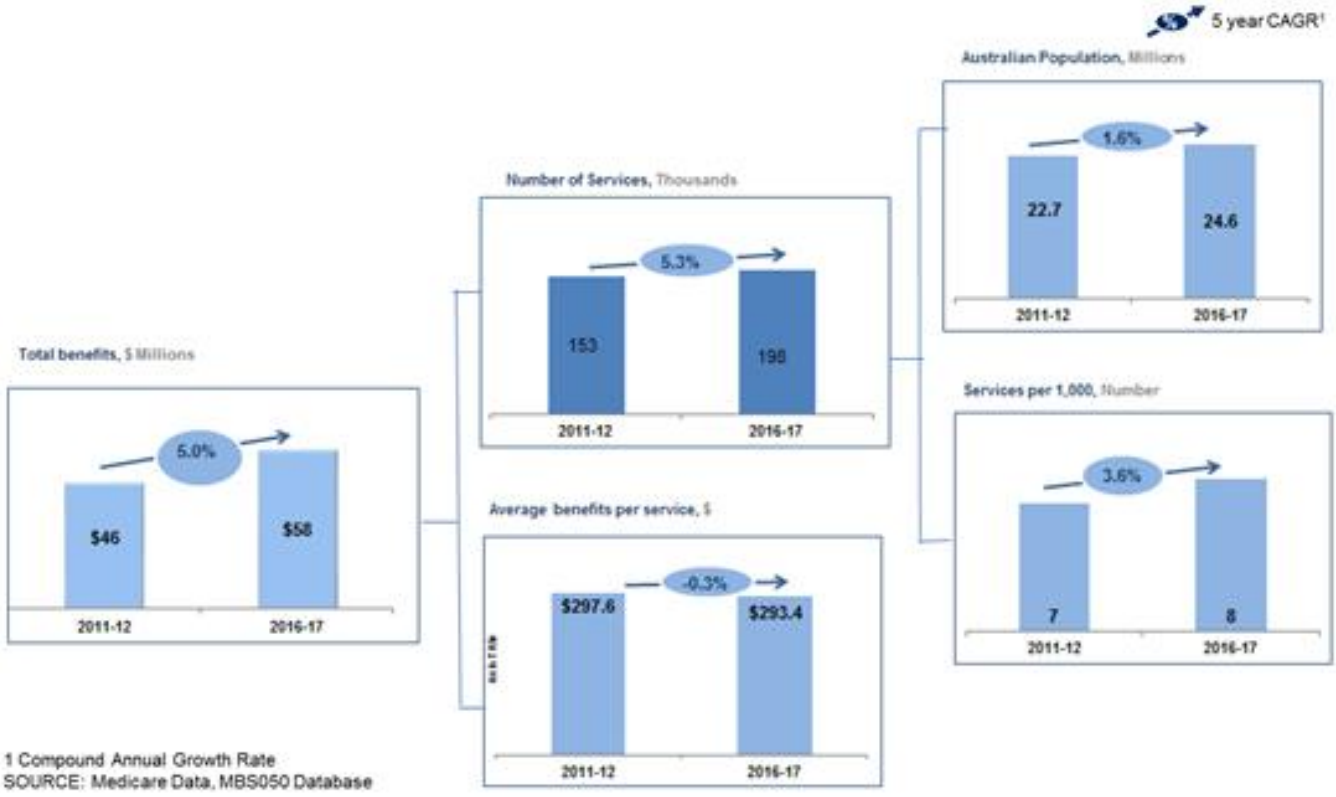


Figure 2: Drivers of plastic and reconstructive surgery item growth, FY2011/12–2016/17

3.4 Summary of the Committee's review approach

The Committee completed a review of its items across five full committee meetings (two teleconferences and three in-person meetings) and two specialty subgroup meetings (one oral and maxillofacial surgery teleconference and one general/skin teleconference). It developed the recommendations and rationales contained in this report during these meetings.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, clinicians and growth rates); service provision (type of clinician, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional clinician and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical journals and other sources, such as professional societies.

3.5 Considerations of particular importance in the field of Plastic and Reconstructive Surgery

Safeguarding Medicare against inappropriate use for cosmetic surgery

Medicare and the broader community hold the view that cosmetic surgery (see box below) is not to be publically funded and should therefore not attract Medicare rebates.

Box 1 Definition of cosmetic surgery (2)

> Cosmetic surgery is defined, for the purposes of a healthcare payer, as any invasive procedure where the primary intention is to achieve what the patient perceives to be a more desirable appearance and where the procedure involves changes to bodily features that have a normal appearance on presentation to the doctor.
>
> In contrast, surgery performed with the goal of achieving a normal appearance, where bodily features have an abnormal appearance on presentation due to congenital defects, developmental abnormalities, trauma, infections, tumours or disease does not fall under the definition of cosmetic surgery. It is a given that "normal appearance" is a subjective notion. Determining whether patients have a normal or abnormal appearance on presentation will rely on the clinical assessment of the treating doctor.

As it has been agreed that Medicare is not to fund cosmetic surgery, it is therefore the responsibility of the Plastic and Reconstructive Clinical Committee to consider the potential for items to be used inappropriately for the purposes of cosmetic surgery and to put in place restrictions to prevent any misuse. A major project led by the Department of Health has

already taken place and has led to changes due to be implemented on 1st November 2018. Although most of the items where cosmetic misuse has been perceived as a risk have now been amended, it remains an additional perspective for the Plastic and Reconstructive Surgery Clinical Committee to be aware of during their review of the in-scope items, which has not been a major consideration for most other clinical committees in the MBS Review.

The problem of body dissatisfaction and the inexorable rise in the uptake of cosmetic surgery by the Australian community is likely to have a significant impact on Medicare and on state public hospital resources because, even if they do not directly fund such procedures, they inevitably fund the correction of any complications of these operations. A recently published journal article suggests that the total costs of the complications alone of cosmetic breast augmentation were in the region of A$200 million over a 5 year period between 2000 and 2015 (3). Mechanisms to reduce complication rates, such as the regulation of cosmetic surgery facilities and restricting the title of "surgeon" to those who are suitably qualified will assist in limiting these cost increases; however, other avenues such as developing public health campaigns to promote positive body image and reduce body dissatisfaction have not been explored. Work to improve body image, particularly in the young, could be highly cost-effective and should be explored by the Commonwealth Government.

It should be noted that the work of the Australian Society of Plastic Surgeons in conjunction with the Department of Health on the "MCRP and Plastic Surgery Items" project, aimed at safeguarding against inappropriate use of item numbers for cosmetic surgery has enabled the introduction of robust measures that are likely to save many millions of dollars of public funds, in particular with regards to the changes to the management of cosmetic breast implant complications. The Plastic and Reconstructive Surgery Clinical Committee suggests that some of these savings could be re-invested in a public health promotion project mentioned above, but also in improving remuneration for high value procedures e.g. skin cancer treatment in general practice, which patients sometimes struggle to access due to clinicians being unable to provide the services for the schedule fee.

3.5.1 General Recommendation 1

The Department of Health should explore the options of public health measures to improve body image satisfaction, especially in the young, and should monitor the costs relating to the complications of cosmetic surgery.

Ensuring the best and most cost-effective treatment for patients with skin cancers

Skin cancer is a major health burden in the Australian community and Plastic and Reconstructive Surgeons play an important role in the treatment of skin cancer. The "Skin Services Review", carried out in 2016, improved the structure of the Schedule regarding the excision of skin lesions and the repair of subsequent defects with skin flaps. Although it is a general rule of the MBS Review to not re-examine items that have been reviewed recently, there are some pressing reasons for the Plastic and Reconstructive Surgery Clinical Committee to consider the recent changes made as part of the Skin Services Review:

- 1) At the time the Skin Services Review was conducted the principle of the complete medical service was less developed. As many patients in the Australian community have multiple skin cancers arising simultaneously it is vital that each skin cancer is regarded as a separate operation in line with the complete medical service concept. To deny this interpretation would result in significant problems for both patients and treating clinicians, as perverse financial incentives would be very strong to bring patients back for multiple operations at different time-points. This may be compounded by the fact that Medicare remuneration for these items is already often below the costs of the procedure. The Principles and Rules Committee (PRC) agrees with the PRSCC in the interpretation that each skin cancer be regarded as a separate operation (see Appendix B).
- 2) The items for full-thickness and partial thickness skin grafts were not addressed by the Skin Services Review, but have significant overlap between the Skin Services Review and the current review because skin grafts are often used for the repair of defects after skin cancer excision. The approach of the Skin Services Review was a useful lens and basis for the Plastic and Reconstructive Surgery Clinical Committee's review of the skin graft items.
- 3) Verbal reports from surgeons and GPs assert that because the remuneration for excision of skin lesions is low and has not increased over the last 6 years (despite the cost of materials such as sutures, instruments and dressings increasing), GPs and surgeons are increasingly reluctant to provide these services in their rooms. Many clinicians have introduced a "facility fee" to cover their costs and as this is not covered by private health insurance, it is a direct cost to the patient. Patients unwilling to pay this fee may seek referral to a public hospital outpatient facility or may request to be treated in a day surgery hospital, where their private health insurance will offer them a rebate. The first option results in increased pressure on public hospital outpatient facilities; however, this is not easily measurable as this activity is coded in a variety of

ways and generally does not use MBS items. The second option supports the interests of owners of day surgery hospitals but is not a cost-effective option, as operating theatre environments are considerably more resource intensive than private rooms with a procedure facility. Due to the "silo" nature of activity measurement between private hospitals, public hospitals and private rooms, it is difficult to fully analyse this problem, but there is no doubt that this is an important issue when overall healthcare expenditure in Australia is taken into account. Therefore, increasing the remuneration of skin lesion excision items in the Schedule and perhaps allowing these services to attract the 100 per cent Medicare rebate when performed in rooms, although at face value may increase Medicare expenditure slightly, is highly likely to result in a global cost saving for the Australian healthcare system. An alternative approach would be to explore the option of private health insurers covering such procedures when they are performed in a non-hospital environment. It is the recommendation of this committee that these options are explored further by the Commonwealth and State Departments of Health.

3.5.2 General Recommendation 2

- Remuneration of skin excision items (in particular items 31356, 31357, 31366 and 31368) should be reconsidered at the time of the 12 month evaluation of the Skin Services Review and should be increased.
- Medicare and other appropriate branches of the Federal and State Departments of Health should collaborate to explore the issue of costs associated with surgical treatment of skin cancers in Australia and look into ways of supporting cost-efficient services in GPs' and surgeons' rooms.

4. Recommendations: General/skin items

4.1 Injectable poly-L-lactic acid administration items

Table 2: Item introduction table for items 14201 and 14202

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
14201	Poly-l-lactic acid, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the national health act 1953 - once per patient	$236.85	64	$12,898	-33.6%
14202	Poly-l-lactic acid, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the national health act 1953	$119.90	387	$39,600	-7.5%

4.1.1 Recommendation 1

- Items 14201 and 14202: No change.

4.1.2 Rationale for Recommendation 1

- The Committee agrees that items 14201 and 14202 appropriately describe current clinical practice and remain safe and effective procedures (4) (5) (6) with no concerns regarding misuse based on MBS data.

4.2 Lipectomy items

Table 3: Item introduction table for items 30165, 30168, 30171 and 30172

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30165	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	$454.85	148	$38,913	-9.4%
30168	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 1 excision only (H) (Anaes.) (Assist.)	$454.85	520	$115,591	-15.7%
30171	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non	$691.75	1,280	$506,895	-6.2%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 2 excisions only (H) (Anaes.) (Assist.)				
30172	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.)	$691.75	89	$37,675	-

4.2.1 Recommendation 2

- Item 30165: Change the item descriptor to remove the requirement to have failed 3 months of conventional (or nonsurgical) treatment.
  - The proposed item descriptor is as follows:
    - Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity; and (b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (Anaes.)(Assist.)
- Items 30168, 30171 and 30172: Remove the requirement for intertrigo or another skin condition that risks loss of skin integrity and the requirement to have failed 3 months of conventional (or nonsurgical) treatment.

- The proposed item descriptors are as follows:
  - Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) the redundant skin and fat interferes with the activities of daily living; and (b) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (c) the procedure involves 1 excision only (Anaes.)(Assist.)
  - Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) the redundant skin and fat interferes with the activities of daily living; and (b) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (c) the procedure involves 2 excisions only (Anaes.)(Assist.)
  - Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) the redundant skin and fat interferes with the activities of daily living; and (b) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (c) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.)

4.2.2 Rationale for Recommendation 2

This recommendation focuses on improving access to MBS funding for appropriate care while preventing potential inappropriate claiming for cosmetic use. These items were reviewed in 2016 and it was decided that changes should therefore be minimal. The recommendations are based on the following:

- Skin excess following massive weight loss is a serious health care issue. Obesity has become a major health issue and obesity surgery has become effective. Patients who lose massive amounts of weight are often devastated by the physical impairment of the skin folds that result and these folds do not resolve with time, exercise or further weight loss (7) (8). The folds cause disability with respect to employment, exercise, deformity and hygiene issues and can contribute to a relapse to obesity in some patients.

- The Committee felt that skin breakdown is not the only legitimate indication for excision of this redundant tissue. Patients who have no intertrigo still describe severe problems, including a heavy, painful dragging sensation from large skin folds. They can also experience lymphoedema of the deposit and skin on skin friction creating pain and discomfort without skin breakdown.
- The Committee also agreed that the restriction requiring patients to have failed three months of conventional treatment is an extreme barrier to those who suffer intermittent skin breakdown problems.
- The Committee believe that the requirement for intertrigo or another skin condition that risks loss of skin integrity in the descriptor of items 30168, 30171 and 30172 disadvantages those patients who maintain immaculate hygiene. Removing the requirement for intertrigo or another skin condition that risks loss of skin integrity from these items will also allow patients with areas of severe excess skin other than breast fat to undergo treatment (e.g. bat wings in arms).. The Committee acknowledges that these recommendations extend access to these items and may require MSAC evaluation.
- The Committee recognises that there is a current MSAC application (9) to create a new MBS item for the repair of severe rectus divarication in post-partum patients with no history of weight loss and no skin irritation yet suffer from severe disabling abdominal wall and back pain. This is a separate issue to skin excess and is more disabling. The Committee supports the creation of this new item.

4.3 Local flap repair items

Table 4: Item introduction table for items 45006, 45009, 45012 and 45015

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45006	Single stage large myocutaneous flap repair to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.)	$1,037.65	589	$365,689	6.6%
45009	Single stage local muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)	$379.05	524	$68,055	10.0%
45012	Single stage large muscle flap repair to 1 defect, (pectoralis major, gastrocnemius,	$635.00	602	$133,602	8.9%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	gracilis or similar large muscle) (Anaes.) (Assist.)				
45015	Muscle or myocutaneous flap, delay of (Anaes.)	$300.75	14	$2,066	-4.9%

4.3.1 Recommendation 3

- Item 45006: Change the item descriptor to exclude claiming in the context of breast reconstruction.
    - The proposed descriptor is as follows:
        - Single stage large myocutaneous flap repair to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle), excluding in the context of breast reconstruction (Anaes.) (Assist.)
- Item 45009: No Change. The Committee recommends that co-claiming of this item with tongue-tie items (30278 & 30281) be reviewed by the Otolaryngology Head and Neck Surgery Clinical Committee.
- Item 45012: Change the item descriptor to exclude claiming in the context of breast reconstruction.
    - The proposed descriptor is as follows:
        - Single stage large muscle flap repair to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle), excluding in the context of breast reconstruction (Anaes.) (Assist.)
    - The Committee recommends increasing the schedule fee of item 45012 to approximately $778.25 to better reflect complexity of the procedure.
- Item 45015: No Change

4.3.2 Rationale for Recommendation 3

This recommendation focusses on simplifying and modernising the MBS. It is based on the following:

- Items 45006 and 45012:
    - Post-mastectomy breast reconstruction is an increasingly common surgical procedure for women who have had a mastectomy (10) (11).

However, there is a high degree of variability in item number usage patterns for this surgery, mainly due to a lack of clarity. This gives patients a degree of unpredictability in terms of billing, which could be avoided if dedicated item numbers were devised. The lack of dedicated items also contributes to the poor statistics available on rates of post-mastectomy breast reconstruction in Australia. In the interests of improving data collection and being able to measure rates of post-mastectomy breast reconstruction it is helpful to separate out the clinical use of muscle and musculocutaneous flaps for breast reconstruction from their use for other defects such as traumatic leg defects. Post-mastectomy breast reconstruction has become a sub-specialist area in its own right and the Committee felt that it is appropriate to have separate MBS item numbers for this work; and therefore exclude use of these items for breast reconstruction.

- A fee increase is recommended for item 45012 as the current remuneration does not accurately reflect the level of complexity in the procedure. It is considered appropriate that the fee should be approximately 75% of the schedule fee for item 45006.

- Item 45009:
  - The Committee considered the use of this item (524 claims) higher than expected as it was expected that use of this item would reduce following the implementation of the Skin Services Review. The Committee agreed that the niche for this item is small. Item 45000 includes local muscle flap repair of the eyelid, nose, lip, neck, hand, thumb, finger or genitals but cannot be used for reconstruction of malignant or non-malignant skin cancer defects (items 31356 to 31376). Items 45201 and 45202 can be claimed for local muscle flaps for the reconstruction of malignant or non-malignant skin lesions. Therefore, the only remaining role for item 45009 should be reconstruction of defects outside of the eyelid, nose, lip, neck, hand, thumb, finger or genitals that are not caused by skin cancer excisions and require a small muscle flap (e.g. a tibialis anterior turnover flap for traumatic leg wound or a buccinator flap for an intraoral defect).
  - The Committee initially suggested adding a minimum size restriction of at least 30 mm in diameter outside of areas described in item 45000 and preventing the use of item 45009 with any of the items 31356 to 31376; however, the data did not support these recommendations (co-

claiming with items 31355-31376 was less than 5 per cent). It was noted that item 45009 was co-claimed with tongue-tie items 30278 or 30281 approximately 13 percent of the time. The Committee referred this issue to the Otolaryngology Head and Neck Surgery Clinical Committee and suggested restricting co-claiming of these items with item 45009.

- The Committee noted co-claiming of item 45009 with breast reconstruction items (45542 or 45539) and parotid gland items (30253 or 30250). The Committee agreed that this was appropriate in external oblique or serratus flaps for breast reconstruction and temporalis turnover flap in the parotid gland.

- Item 45015: The Committee considered this item to be consistent with current clinical practice and requiring no change.

4.4 Abrasive therapy

Table 5: Item introduction table for items 45021 and 45024

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45021	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)	$177.35	206	$27,621	15.6%
45024	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)	$398.55	132	$72,455	-17.7%

4.4.1 Recommendation 4

- Item 45021: Change the item descriptor to specify that this item is to be used on the face. Include a restriction to limit the number of times this item can be claimed. Include a requirement for photographic evidence to be included in the patient notes.

- The proposed item descriptor is as follows:

  - Abrasive therapy for severely disfiguring scarring of face resulting from trauma, burns or acne - limited to one claim per patient per episode.

Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.)

- Item 45024: Delete.

4.4.2 Rationale for Recommendation 4

This recommendation focuses on simplifying and modernising the MBS, improving the safety and efficacy of patient care and ensuring care aligns with professional standards. It is based on the following;

- Abrasive therapy has largely been replaced by laser therapy; however, the Committee felt that this service is still indicated occasionally. This is supported by a 2015 literature review (12). MBS data showed that GPs supplied many of these procedures in FY 2016/17, which the Committee considered inconsistent with the original intent of the item. The Committee recommends limiting the use of the item to one aesthetic area of the face as it is unlikely that one aesthetic area alone will be subject to misuse. The Committee also agreed that the item should cover all abrasive treatment provided in a single episode of care in line with the principle of the complete medical service and recommends adding a limit of one claim per patient episode.
- The Committee considered item 45024 at risk of inappropriate utilisation and felt that it was reasonable to consolidate it into item 45021.

4.5 Direct and indirect flap items

Table 6: Item introduction table for items 45209, 45212, 45215, 45218, 45221, 45224, 45227, 45230, 45233, 45236, 45239 and 45240

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45209	Direct flap repair (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)	$473.75	99	$26,625	-7.0%
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	$235.05	106	$16,198	-3.6%
45215	Direct flap repair, cross leg, first stage (Anaes.) (Assist.)	$1,014.05	-	$-	-100.0%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45218	Direct flap repair, cross leg, second stage (Anaes.) (Assist.)	$454.85	1	$341	0.0%
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	$261.55	34	$2,576	-10.1%
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	$117.55	53	$3,300	-5.9%
45227	Indirect flap or tubed pedicle, formation of (Anaes.) (Assist.)	$445.40	88	$18,385	3.5%
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	$222.75	60	$5,757	5.9%
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)	$473.75	135	$40,894	6.6%
45236	Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (Anaes.)	$371.50	44	$10,821	7.3%
45239	Direct, indirect or local flap, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.)	$261.55	648	$100,160	-3.3%
45240	Direct, indirect or local flap, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)	$261.55	75	$9,989	4.6%

4.5.1 Recommendation 5

- Item 45209: Change the item descriptor to include 'forehead and cross leg flap'. Indicate this item is the first of a two-stage process.
    - The proposed item descriptor is as follows:
        - Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (Anaes.) (Assist.)
- Item 45212: Change the item descriptor to include 'forehead and cross leg flap'. Specify this item is for the second or third stage of flap repair.
    - The proposed item descriptor is as follows:

- Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (Anaes.) (Assist.)

- The Committee advises that use of these items should be monitored and reviewed again in 12-24 months to determine whether the items are being used appropriately.
- Items 41215 and 45218: Consolidate into items 45209 and 45212, respectively.

4.5.2 Rationale for Recommendation 5

This recommendation focuses on simplifying and modernising the MBS. It is based on the following.

- Items 45209, 45212, 45215 and 45218:
    - Multi-staged skin flap reconstructions have long been used in plastic surgery. Although these classic techniques are still indicated in some circumstances (13), the high reliability and improved outcomes of microsurgical free flaps has meant that they have largely replaced these traditional flaps. For example, MBS data indicate that cross leg flaps are rarely performed (fewer than 6 cross leg flap services per year) as they have been largely superseded by microsurgical techniques (except for defect salvage after failed microsurgical repair). For this reason consolidating items 45215 and 41218 with items 45209 and 45212 respectively, was considered appropriate and results in simplification of the Schedule. The inclusion of cross leg flaps in items 45209 and 45212 would result in a lower fee being payable for cross leg flaps; however, the Committee felt that these procedures are no longer best clinical practice and would only be an option when no other graft or flap is successful and thus would have little impact on patients. In contrast, the forehead flap is an ancient technique which continues to be used in current clinical practice and is not specified in the current item descriptors.
    - The Committee recommends including "pedicled" in the item descriptors in order to increase clarity regarding the type of flap these items refer to.

4.5.3 Recommendation 6

- Items 45221, 45224: No change.

4.5.4 Rationale for Recommendation 6

- The Committee considered that these procedures remain clinically relevant and provide good outcomes for patients. This is supported in the literature (14).

4.5.5 Recommendation 7

- 45227, 45230 and 45233: No change.
- 45236: Delete

4.5.6 Rationale for Recommendation 7

- Although the tubed pedicle flap has largely been replaced by other reconstructive techniques, it still has its place in the library of plastic and reconstructive techniques (15); therefore, items 45227, 45230 and 45233 represent rarely used but still valuable items.
- The Committee recommends deletion of item 45236 as the concept of a separate surgical procedure to "spread a pedicle" is not consistent with modern surgical practice. Its deletion reflects modernising the Schedule.

4.5.7 Recommendation 8

- Items 45239 and 45240: Consolidate into one item and include a restriction to limit the number of times this item can be claimed per flap.
    - The proposed item descriptor is as follows:
        - Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap (Anaes.)

4.5.8 Rationale for Recommendation 8

This recommendation focuses on simplifying and modernising the MBS and encouraging appropriate use of items. It is based on the following.

The recommendation to consolidate items 45239 and 45240 prevents co-claiming of two separate items for a single revision procedure. The Committee recommends limiting this item to one claim per flap at one time in order to minimise inappropriate use and provide for a Complete Medical Service.

4.6 Free grafting split skin and full thickness items

Table 7: Item introduction table for items 45400, 45403, 45439, 45442, 45445, 45448 and 45451

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45400	Free grafting (split skin) of a granulating area, small (Anaes.)	$204.70	1,161	$108,680	0.9%
45403	Free grafting (split skin) of a granulating area, extensive (Anaes.) (Assist.)	$407.50	549	$151,363	-3.4%
45439	Free grafting (split skin) to 1 defect, including elective dissection, small (Anaes.)	$284.35	5,777	$1,037,902	2.2%
45442	Free grafting (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.)	$586.50	6,144	$2,233,238	9.1%
45445	Free grafting (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould) (Anaes.) (Assist.)	$556.60	4,430	$1,611,584	5.4%
45448	Free grafting (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.)	$376.00	967	$237,365	-0.8%
45451	Free grafting (full thickness) to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.)	$473.75	36,470	$12,694,876	5.0%

4.6.1 Recommendation 9

- Items 45400, 45403, 45439, 45442, 45445 and 45448: Restructure these items into two new items; one each for free grafting of small and large defects.
    - The proposed consolidated new item descriptors are as follows:

- Split thickness skin graft to a small defect defined as: (a) less than 40 mm in diameter on areas below the knee, distal to the ulnar styloid and above the clavicle; and, (b) less than 80 mm in diameter on any other part of the body (Anaes.)(Assist.)
- The Committee recommends a schedule fee similar to that of free grafting of a small area with elective dissection (item 45439; $284.35).
- Split thickness skin graft to a large defect defined as: (a) 40 mm or more in diameter on areas below the knee, distal to the ulnar styloid and above the clavicle; and, (b) 80 mm or more in diameter on any other part of the body (Anaes.)(Assist.)
- The Committee recommends a schedule fee similar to that of free grafting of an extensive area with elective dissection (Item 45442; $586.50).

- The Committee recommends that each site where a skin graft is required be considered a separate procedure in line with the complete medical service concept. This would mean that up to 3 items would be claimable, as appropriate, for each site where a lesion or defect is treated. The Committee suggested that if this is not the case there would be a perverse incentive for the clinician to perform multiple operations on a patient on different days when multiple incisions could more easily be performed in the same surgical episode.
- Item 45451: Change the descriptor to better describe the service and restrict use of this item to defects greater than 5 mm in diameter. Delete reference to male pattern baldness.
    - The proposed item descriptor is as follows:
        - Full thickness skin graft to 1 defect with an average diameter of 5 mm or more (Anaes.) (Assist.)
- As above the Committee recommends that each site where a skin graft is required should be considered a separate procedure in line with the complete medical service concept. The Committee also suggests that co-claiming of this item with skin cancer excision items should be monitored.

4.6.2 Rationale for Recommendation 9

This recommendation is focused on clarifying, simplifying and modernising the MBS. It is also based on providing consistency between different sections of the Schedule and

consolidation of these items will separate repair from revision, simplifying the Schedule. In particular, in this section there is a legitimate need to claim skin graft item numbers along with item numbers that were previously considered by the Skin Services Review, most commonly for skin cancer surgery. The Committee reflected on the changes and restructure of the Skin Services Review items when drawing up the new proposed items for skin grafting.

- Items 45400, 45403, 45439, 45442, 45445 and 45448:
    - The Committee agreed to remove the term 'granulating area' from the descriptor of items 45400 and 45403 as it is inconsistent with modern practice. Historically, wounds were left to granulate for long periods of time prior to skin graft procedures; however current practice is to excise wounds acutely and to skin graft them immediately.
    - There is evidence that reducing the period of bed rest in the context of skin grafts can minimise the length of time that the patient is immobilised and in hospital (16).
    - Reference to a mould (item 45445) is no longer appropriate in item descriptors regarding split skin grafts because of changes in practice. Moulds were commonly used in the past, but have now been replaced by techniques such as vacuum-assisted dressings. The Committee considered clinicians may be using this item for tie over dressings, which is not what the item is intended for. The recommendation to consolidate items will help to clarify indications and enable correct use of the Schedule.
    - Furthermore, reference to elective dissection (items 45439, 45442 and 45445) has been removed as the procedure of skin grafting is the same whether it is performed in an elective or emergency setting.
    - When considering the fee for the new consolidated small and large defect skin graft items the Committee considered how they compared to the remuneration for muscle, myocutaneous or skin flaps (Item 45201; $ 413.95) and elective dissection free grafting items (item 45439; $284.35 and item 45442; $586.50) as a split skin graft represents a significant level of work and the amount of post-operative care is frequently much more intensive than with a flap. Moreover, the elective dissection items (45439 and 45442) are used much more frequently than items for free grafting of a granulating area (items 45400 and 45403) and the Committee considers that this increase in fees is unlikely to have a significant impact.

- The Committee recommends allowing co-claiming of biopsy items with these items in the interest of the patient as this would encourage surgeons to perform biopsies, if required, in the same surgical episode.
- The Committee also discussed that free grafting for very extensive defects for necrotising fasciitis (which may currently represent a few claims for item 45442) have been incorporated into the proposed burns items.

- Item 45451:
  - The Committee recommends amending the descriptor to reduce the potential for inappropriate use by limiting its use to defects of greater than 5 mm as defects smaller than this can usually be closed by direct suturing. The Committee was also concerned that this item may be used for very small 'punch grafts' which is not what the item was intended for as this does not require the same level of work. The Committee agreed that imposing a lower limit on the size of the defect that can be repaired with a full thickness graft would also prevent this item being used for punch grafts. This amendment is likely to reduce use of this item and preserve the item for those cases where a full-thickness skin graft is truly indicated.
  - The Committee recommends deleting the reference to male pattern baldness as this is a technique which is no longer widely used, having been replaced by hair micrografts / follicular transplantation (17). The additional 5mm specification also prevents its use in these cases.
  - As many patients in the Australian community have multiple skin cancers arising simultaneously it is vital that each skin cancer is regarded as a separate operation in line with the complete medical service concept. The Principles and Rules Committee agrees with the PRSCC in this interpretation (see Appendix B). To deny this interpretation would result in significant problems for both patients and treating clinicians, as perverse incentives would be very strong to bring patients back for multiple operations at different time-points.

4.7 Microvascular procedures

Table 8: Item introduction table for items 45496, 45500, 45501, 45502, 45503, 45504, 45505, 45561, 45562, 45563, 45564, 45565 and 47732

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45496	Flap, free tissue transfer using microvascular techniques - revision of, by open operation (Anaes.)	$416.05	567	$106,918	11.9%
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)	$1,090.35	782	$563,197	9.9%
45501	Microvascular anastomosis of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)	$1,774.70	41	$38,783	0.0%
45502	Microvascular anastomosis of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)	$1,774.70	46	$25,279	4.5%
45503	Micro-arterial or micro-venous graft using microsurgical techniques (Anaes.) (Assist.)	$2,030.35	1,111	$780,475	36.4%
45504	Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)	$1,774.70	470	$587,029	-2.6%
45505	Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)	$1,774.70	794	$553,273	1.7%
45561	Microvascular anastomosis of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.)	$1,774.70	94	$62,353	53.6%
45562	Free transfer of tissue involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous	$1,099.40	663	$331,913	4.8%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)				
45563	Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	$1,099.40	3,077	$2,568,637	4.7%
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$2,546.30	864	$1,474,037	13.8%
45565	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, conjoint specialist surgeon (H) (Assist.)	$1,909.80	753	$898,275	14.7%
47732	Vascularised pedicle bone graft, harvesting of, in conjunction with another service	$376.55	90	$12,108	8.4%

4.7.1 Recommendation 10

- Item 45496: No change.
- Item 45500: Change the item descriptor to restrict claiming to either an artery or a vein.
    - The proposed item descriptor is as follows:
        - Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit, not claimable for both artery and vein by the same provider (Anaes)(Assist).
- Proposed new Item 4550X:
    - The proposed item descriptor is as follows:
        - Microvascular repair using microsurgical techniques, with restoration of continuity of artery and vein of distal extremity or digit, including anastomoses of all required vessels for that extremity or digit (Anaes)(Assist).

The Committee recommends increasing the schedule fee of the newly consolidated item in accordance with the multiple operations rule to reflect the fact that two services are combined into one.

- Items 45501 and 45502: Consolidate these items into two new items
    - The proposed consolidated new item descriptors are as follows:
        - Microvascular anastomosis of artery or vein using microsurgical techniques, for replantation or revascularisation of limb or digit, where the limb or digit is devitalised and the repair is critical for restoration of blood supply (Anaes)(Assist).
        - Microvascular anastomoses of artery and vein using microsurgical techniques, for replantation or revascularisation of limb or digit, where the limb or digit is devitalised and the repair is critical for restoration of blood supply including anastomoses of all required vessels for that extremity or digit, unless a micro-arterial or micro-venous graft is being used (Anaes)(Assist).
- Item 45503: Change the item descriptor to restrict use in cardiac surgery and discourage additional grafts which may not contribute to improving patient outcomes.
    - The proposed item descriptor is as follows:

- Micro-arterial or micro-venous graft using microsurgical techniques, where the graft is critical for restoration of blood supply, including harvest of graft and suturing of all related anastomoses (not to be claimed in the context of cardiac surgery) (Anaes.) (Assist.)

- Items 45504 and 45505: Consolidate these two items into two new items in line with the complete medical service concept. Change the item descriptors to exclude claiming in the context of breast reconstruction.
    - The proposed consolidated new item descriptors are as follows:
        - Microvascular anastomosis of artery or vein(s) using microsurgical techniques, for free transfer of tissue including setting in of free flap, excluding in the context of breast reconstruction (Anaes.)(Assist.)
        - Microvascular anastomosis of artery and vein(s) using microsurgical techniques, for free transfer of tissue including setting in of free flap, excluding in the context of breast reconstruction (Anaes.)(Assist.)

The Committee recommends increasing the schedule fee of the newly consolidated item in accordance with the multiple operations rule to reflect the fact that two services are combined into one.

- Item 45561: Change the item descriptor to better describe the service.
    - The proposed item descriptor is as follows:
        - Microvascular anastomosis of artery and/or vein where deemed necessary to salvage a vascularly compromised pedicled or free flap, either during the primary procedure or at a subsequent return to theatre (Anaes)(Assist).
- Item 45562: Change the item descriptor to better describe the service and exclude claiming in the context of breast reconstruction. Delete reference to male pattern baldness.
    - The proposed item descriptor is as follows:
        - Free transfer of tissue (microvascular free flap) involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for breast reconstruction (Anaes.) (Assist.)
- Proposed new item 455M1 for dissection of a pedicled perforator flap.

- The proposed item descriptor is as follows:
  - PERFORATOR FLAP, raising on a named source vessel, for pedicled transfer for head and neck or other non-breast reconstruction.

- Proposed new item 455M2 for dissection of a free perforator flap.
  - The proposed item descriptor is as follows:
    - PERFORATOR FLAP, such as anterolateral thigh flap or similar, raising in preparation for microsurgical transfer of a free flap for head and neck or other non-breast reconstruction.

- Items 45563: Change the item descriptor to better describe the service and clarify indication for claiming. Delete reference to male pattern baldness.
  - The proposed item descriptor is as follows:
    - Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, including direct repair of secondary cutaneous defect if performed. Requires formal dissection of the neurovascular pedicle. Not to be used for simple V-Y flaps or other standard flaps, such as rotation or keystone. Not to be claimed with skin excision items 31200 to 31376 (Anaes.) (Assist.)

- Items 45564 and 45565: Change the item descriptors to exclude claiming in the context of breast reconstruction.
  - The proposed item descriptors are as follows:
    - Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect , involving anastomoses of all required vessels using microvascular techniques and including raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon, excluding in the context of breast reconstruction (H) (Anaes.) (Assist.)
    - Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques and including raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of

tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, conjoint specialist surgeon, excluding in the context of breast reconstruction (H)(Anaes.)(Assist.)

- Proposed new item: To be used when a single surgeon is required for the procedure
    - The proposed item descriptor is as follows:
        - Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect involving anastomoses of all required vessels using microvascular techniques and including raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—single surgeon, excluding in the context of breast reconstruction (H) (Anaes.) (Assist.)
- Item 47732: No change
- New Item 455M3: Create a new item for a single surgeon performing a free flap with a bony component.
    - The proposed item descriptor is as follows:
        - Free transfer of tissue with a vascularised bone component, (including chimeric / composite flap) for the repair of major defect of the head and neck or other non-breast defect, including harvesting of flap (including osteotomies) raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, including fixation of bony element and inset of tissue at recipient site, anastomoses of all required vessels using microvascular techniques and direct repair of secondary cutaneous defect if performed, excluding bony reshaping for purposes of reconstruction of maxilla, mandible or skull base. other than a service associated with a service to which item 30165, 30168,

30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—single surgeon, (H) (Anaes.) (Assist.).

- New Item 455M4: Create a new item for conjoint surgeons (with a principal specialist) performing a free flap with a bony component.
    - The proposed item descriptor is as follows:
        - Free transfer of tissue with a vascularised bone component, (including chimeric / composite flap) for the repair of major defect of the head and neck or other non-breast defect, including harvesting of flap (including osteotomies) raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, including fixation of bony element and inset of tissue at recipient site, anastomoses of all required vessels using microvascular techniques and direct repair of secondary cutaneous defect if performed, excluding bony reshaping for purposes of reconstruction of maxilla, mandible or skull base *other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies*—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)
- New Item 455M5: Create a new item for conjoint surgeons (with conjoint specialist) performing a free flap with a bony component.
    - The proposed item descriptor is as follows:

- Free transfer of tissue with a vascularized bone component, (including chimeric / composite flap) for the repair of major defect of the head and neck or other non-breast defect, including harvesting of flap (including osteotomies) raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, including fixation of bony element and inset of tissue at recipient site, anastomoses of all required vessels using microvascular techniques and direct repair of secondary cutaneous defect if performed excluding bony reshaping for purposes of reconstruction of maxilla, mandible or skull base, *other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies*—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)

- New Item 455M6: Create a new item for double free flaps where at least one has a bony component (principal surgeon of two surgeon team).
    - The proposed item descriptor is as follows:
        - Double free flap including ONE free transfer of tissue with a vascularized bone component, for the repair of major defect of the head and neck or other non-breast defect, including harvesting of flap (including osteotomies) raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, including fixation of bony element and inset of tissue at recipient site, anastomoses of all required vessels using microvascular techniques AND A SECOND FREE FLAP, HARVESTED ON A DIFFERENT PEDICLE AND WITH ANOTHER SET OF ANASTOMOSES and direct repair of secondary cutaneous defect if performed excluding bony reshaping for purposes of reconstruction of maxilla, mandible or skull base other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)

- New Item 455M7: Create a new item for double free flaps where at least one has a bony component (conjoint surgeon of two surgeon team).
    - The proposed item descriptor is as follows:
        - Double free flap including ONE Free transfer of tissue with a vascularized bone component, for the repair of major defect of the head and neck or other non-breast defect, including harvesting of flap (including osteotomies) raising of tissue on a vascular pedicle, preparation of recipient vessels, transfer of tissue, including fixation of bony element and inset of tissue at recipient site, anastomoses of all required vessels using microvascular techniques AND A SECOND FREE FLAP, HARVESTED ON A DIFFERENT PEDICLE AND WITH ANOTHER SET OF ANASTOMOSES and direct repair of secondary cutaneous defect if performed excluding bony reshaping for purposes of reconstruction of maxilla, mandible or skull base other than a

service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)

- New Item 455M8: Create a new item for double free flaps (no bony component) (principal surgeon of two surgeon team).
    - The proposed item descriptor is as follows:
        - Double free flap including two free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques and including raising each flap of tissue on a separate vascular pedicle, preparation of recipient vessels, transfer of tissue, inset of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon, excluding in the context of breast reconstruction (H) (Anaes.) (Assist.)
- New Item 455M9: Create a new item for double free flaps (no bony component) (conjoint surgeon of two surgeon team).
    - The proposed item descriptor is as follows:
        - Double free flap including two free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques and including raising each flap of tissue on a separate vascular pedicle, preparation of recipient vessels, transfer of tissue, inset of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, conjoint specialist surgeon, excluding in the context of breast reconstruction (H) (Anaes.) (Assist.)

4.7.2 Rationale for Recommendation 10

This recommendation is focused on clarifying, simplifying and modernising the MBS. It is based on the following.

- Items 45496: The Committee considers this item clinically relevant and requiring no change
- Items 45500 and 4550X:
    - Normally to restore blood flow to an extremity or a digit both an artery and a vein have to be repaired. Adhering to the concept of the complete medical service, wherever possible, it would be appropriate to encourage providers to claim a single item which includes both the repair of an artery and a vein, which is the rationale behind the generation of new combined item. The Committee also recommends maintaining item 45500 to account for cases of conjoint surgery where each surgeon repairs either an artery or a vein.
- Items 45501 and 45502:
    - The Committee discussed microvascular anastomosis in the context of replantation of a limb or digit and considered that the current Schedule and financial incentive may incentivise clinicians to perform extra anastomoses when not clinically indicated. The Committee agreed performing extra anastomoses to allow for some redundancy is often clinically indicated in these procedures and recommend the above descriptors to allow for this, while also specifying that any anastomosis performed must be critical for repair of blood supply. The single artery or vein and combined items account for the concepts described above for items 45500 and 4550X.
- Item 45503:
    - The Committee noted the high usage of item 45503. This is an uncommon procedure in plastic and reconstructive surgery; however, MBS data shows that this item is used much more often than items 45504 and 45505 and shows large interstate variation. MBS data shows that this item is commonly co-claimed with items for surgery for ischaemic heart disease (38496-38509) and the Committee suggests restricting this item to non-cardiac indications. This has been discussed with and approved by a cardiac surgery representative of the Cardiac Clinical Committee. The Plastic and Reconstructive Surgery Clinical

Committee agree that this item is used legitimately in free flaps, replants and ischaemic partial amputation cases.

- Items 45504, 45505, 45562, 45564 and 45565
    - The Committee felt that it is appropriate to have separate MBS item numbers for breast reconstruction; and therefore exclude use of these items for breast reconstruction.
- Items 45504 and 45505:
    - The recommendations regarding free flap item changes follow the complete medical services concept wherever possible. Free tissue transfer almost always requires anastomosis of both an artery and a vein, rendering it appropriate to combine these into a single descriptor for most cases; however, to account for cases when different surgeons are operating together a standalone item accounting for anastomosis of either an artery or a vein is required. The Committee felt the fee for the new consolidated item should include anastomoses of artery and multiple veins due to the current incentive to perform an extra anastomosis of a vein in order to claim 45505 twice.
- Item 45561:
    - The Committee noted a significant increase in use of item 45561 with only thirteen providers claiming the item in 2016/17. The Committee considered this suggestive of misuse by a few providers. The Committee discussed reducing the fee; however, decided that changing the descriptor to reduce possible inappropriate use was appropriate. The Committee felt the current descriptor does not adequately describe the procedure as the term 'supercharging' is no longer current. However, the procedure remains useful to salvage a pedicled flap with vascular insufficiency or a free flap where existing two anastomoses remain patent but insufficient either at the time of initial surgery or at a return to theatre. The Committee recommends modifying the descriptor to specify what the item is used for and to better describe modern clinical practice.
- Item 45562:
    - This recommendation is based on the rationale of simplification of wording as the term ‘neurovascular’ is superfluous in the item descriptor.
- Item 455M1:

Perforator flaps have evolved in clinical practice since the last revision of the MBS. They are an intrinsic part of modern surgical practice and their raising and dissection represent additional workload compared with other flaps, as well as a high degree of skill and training for successful execution. The recommendation is therefore around modernisation of the schedule. Fee recommendations would be the same as for 45533A.

- Item 455M2:
    - Perforator flaps have evolved in clinical practice since the last revision of the MBS. They are an intrinsic part of modern surgical practice and their raising and dissection represent additional workload compared with other flaps, as well as a high degree of skill and training for successful execution. The recommendation is therefore around modernisation of the schedule. Fee recommendations would be the same as for 45533B.
- Item 45563:
    - The Committee felt that the increase in use over 5 years was high and the regional variation surprising, which indicates that the item descriptor may require tightening. The Committee felt that as this is a complex plastic surgical procedure, usually requiring magnification and specialist dissection skills and is inappropriate for General Surgeons and GPs to be claiming. The Committee suggested this item is being used for flap repair with skin lesion excision items (31200 to 31376), with the data showing approximately 77 per cent of claims of item 45563 in 2017/18 co-claimed with skin excision items. Therefore, the Committee agreed to prevent co-claiming of item 45563 with skin lesion excision items. Rewording of this descriptor is an attempt to clarify the procedure and ensure the number is used for intended indication (restoration of digital pulp sensation).
    - The adjustment to the wording of this descriptor will improve clarity and enable clinicians to appropriately claim this item.
- Items 45564 and 45565:
    - The Committee considered items 45564 and 45565 to accurately reflect the complete medical service concept and appropriately reflect best practice. The concept of conjoint surgery for free tissue transfer remains valid and is often desirable in terms of reducing anaesthetic

time and complications for patients. This element has therefore been retained.

- The Committee discussed microvascular procedures in the context of rural or remote locations and were concerned that given the new three item rule for a Complete Medical Service single surgeons in these locations will be disadvantaged. The Committee agreed that there should be incentive for conjoint surgeons in these procedures; however, this is not always possible. The Committee suggested creation of a new item number for the situation when a single surgeon is required to perform a free tissue transfer. The proposed descriptor is based on item 45564 and includes a schedule fee based on the combination of items 45504, 45505 and 45562 in accordance with the multiple operations rule as these items would normally be claimed by a single surgeon performing a free tissue transfer.
- The Committee agreed that stand alone items should remain for the infrequent occasion when an additional surgeon is required for a small component of a larger microvascular procedure.

- Item 47732: The Committee considered this item consistent with modern clinical practice and requiring no change.
- New items: The Committee considered the creation of new items is consistent with modern clinical practice and modernisation of the schedule. The Committee noted that no new items have been created for double free flaps surgery because this surgery is not recommended to be performed by a single surgeon.
- New items for a free flap with a bony component: The Committee considered that conjoint surgery is a standard practice and is likely to reduce the duration of surgery.
- The PRSCC recognises that for complex microvascular reconstruction procedures it may not always be possible to limit an individual episode of care to three items Examples of such cases are replantation of amputated parts and head and neck cancer resections and reconstruction. The commonality that these cases hold is that they involve highly variable numbers of individual procedures and often take in excess of 12 hours to carry out.

4.8 Scar revision items

Table 9: Item introduction table for items 45506, 45512, 45515 and 45518

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45506	Scar, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)	$219.95	3,930	$814,775	4.1%
45512	Scar, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)	$295.70	1,227	$218,366	1.7%
45515	Scar, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)	$186.50	2,642	$289,288	4.4%
45518	Scar, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.)	$225.70	3,311	$441,516	9.4%

4.8.1 Recommendation 11

- Items 45506 and 45512: No change.
- Item 45515: Change the item descriptor to reduce risk of cosmetic misuse.
  - The proposed item descriptor is as follows:
    - Scar, other than on face or neck, not more than 7 cms in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty, not in conjunction with the insertion of breast implants for cosmetic purposes. The incision made for revision of the scar must not be used as an approach for another procedure (including non-rebatable procedures). Sufficient

photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.)

- Item 45518: Change the item descriptors to reduce risk of cosmetic misuse.
  - The proposed item descriptor is as follows:
    - Scar, other than on face or neck, more than 7cms in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty, not in conjunction with the insertion of breast implants for cosmetic purposes. The incision made for revision of the scar must not be used as an approach for another procedure (including non-rebatable procedures). Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.)

4.8.2 Rationale for Recommendation 11

This recommendation is in line with the principle of protecting Medicare from potential cosmetic misuse.

- Item 45506: The Committee discussed introducing a lower size limit to this item; however, indications for this item include very small scars on the face and further restrictions may limit legitimate use, therefore the Committee recommends no change.
- Item 45512: The Committee considered this item to be consistent with modern best practice and requiring no change.
- Items 45515 and 45518: The Committee considered these items potentially subject to inappropriate use for the revision of cosmetic breast implants. Specifying recording of photographic evidence and the explicit wording around the exclusion of insertion of breast implants concurrent with scar revision will add clarity to the descriptors and assist in preventing cosmetic misuse. These recommendations are in line with protecting the Schedule from potential cosmetic misuse, which is economically vital for Medicare as evidenced by the literature (3).

4.9 Tissue expansion items

Table 10: Item introduction table for items 45566, 45568 and 45572

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45566	Tissue expansion not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)	$1,071.20	984	$775,874	45.5%
45568	Tissue expander, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)	$443.70	97	$21,339	-6.4%
45572	Intra-operative tissue expansion performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.)	$291.70	528	$39,188	16.7%

4.9.1 Recommendation 12

- Item 45566: Change the item descriptor to clarify indication.
    - The proposed item descriptor is as follows:

    - Insertion of a temporary prosthetic tissue expander which requires subsequent removal, including all attendances for subsequent expansion injections, not to be used for breast or post-mastectomy tissue expansion. (Anaes.)(Assist.)

- Item 45568: Change the item descriptor to allow for situations when excision of fibrous capsule is not required.
    - The proposed item descriptor is as follows;

    - Tissue expander, removal of, including complete excision of fibrous capsule where performed (Anaes.)(Assist.)

- Item 45572: Change the item descriptor.
    - The proposed item descriptor is as follows:

    - Intra-operative tissue expansion using a prosthetic tissue expander performed under general anaesthetic or intravenous sedation during an

operation when combined with a service to which another item in Group T8 applies including expansion injections, not to be used for breast tissue expansion (Anaes.)

4.9.2 Rationale for Recommendation 12

These recommendations update the item descriptors in line with modern surgical practice, separate out post-mastectomy breast reconstruction for reasons mentioned previously and clarify indications for claiming of these items to assist clinicians in appropriate selection and claiming of item numbers.

- Item 45566:
    - The Committee observed MBS data and suspected that this item is not being used as it was originally intended. This item was originally intended for situations such as an insertion of a tissue expander in a child with a large congenital naevus (e.g. in a scalp), however the item may be being used as a route to providing two-stage cosmetic breast augmentation. The descriptor will exclude use in the breast as there are other items specifically for tissue expanders to be inserted in the breast (e.g. item 45539)
    - In addition, the item is being used mainly by urologists (approximately 70% of services. After consultation with the Urology Clinical Committee, it appears that this use may relate to the introduction of an injectable hydrogel spacer (commercially sold as SpaceOAR) into the perirectal space that assists in reducing the dose of radiotherapy to the rectum in prostate cancer treatment. Whilst this procedure is likely to be clinically useful and legitimate it is not of the same magnitude as the procedure originally intended by this descriptor. The Plastic and Reconstructive Surgery Clinical Committee felt it would be appropriate for the Urology Clinical Committee to recommend the creation of a separate item for this procedure. In the meantime, item 45572 should be used for this purpose, if no other item is available, as it more closely matches the level of complexity of this procedure.
- Item 45568: This item remains clinically relevant, however the Committee agreed that excision of fibrous capsule is not always required when removing a tissue expander.
- Item 45572: The Committee agreed that this item remains clinically relevant, however recommend removing the reference to male pattern baldness as this

is no longer performed in modern practice. The Committee noted that this item is often claimed with item 45539 (insertion of tissue expanders for breast reconstruction) and agreed that item 45572 should not be used in this context.

4.10 Closure of abdomen items

Table 11: Item introduction table for items 45569 and 45570

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45569	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)	$677.60	508	$92,914	4.5%
45570	Closure of abdomen, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	$914.95	507	$133,198	7.8%

4.10.1 Recommendation 13

- Items 45569 and 45570: Consolidate into one new item and change the descriptor to be consistent with modern surgical practice.
    - The proposed consolidated item descriptor is as follows:

- Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, to be used following the harvest of an autologous flap, being a service associated with items 45562, 45564, 45565 or 45530 including repair of the musculoaponeurotic layer of the abdomen (including insertion of prosthetic mesh where used) (Anaes.) (Assist.)

The Committee recommends a schedule fee for this combined item to be set on a cost neutral basis using a weighted average fee based on current usage of items 45569 and 45570.

4.10.2 Rationale for Recommendation 13

This recommendation is based on the principle of simplification of the Schedule and the complete medical service.

- These two items as they currently stand are two components of a single procedure and are nearly always performed together, as indicated by the MBS usage data. Therefore, it is simpler and clearer to combine them.
- The Committee considered it highly unusual for a patient having a flap taken from the abdomen not to have repair of the musculoaponeurotic layer.

4.11 Facial paralysis items

Table 12: Item introduction table for items 45575, 45578 and 45581

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45575	Facial nerve paralysis, free fascia graft for (Anaes.) (Assist.)	$720.20	89	$25,200	1.9%
45578	Facial nerve paralysis, muscle transfer for (Anaes.) (Assist.)	$834.05	24	$7,601	-3.7%
45581	Facial nerve palsy, excision of tissue for (Anaes.)	$276.80	92	$10,926	2.3%

4.11.1 Recommendation 14

- Items 45575 and 45578: No change
- Item 45581: Change the descriptor to update terminology.
    - The proposed item descriptor is as follows:
        - Facial nerve paralysis, excision of tissue for (Anaes.)

4.11.2 Rationale for Recommendation 14

This recommendation is based on the modernisation of the terminology in the descriptors.

- "Palsy" is an unscientific and archaic term which has no place in the modern lexicon of the Schedule.

4.12 Eyelid surgery items

Table 13: Item introduction table for items 45614 and 45625

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45614	Eyelid, whole thickness reconstruction of, other than by direct suture only (Anaes.) (Assist.)	$587.60	1,401	$444,507	4.9%
45625	Ptosis of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.)	$187.55	17	$2,121	13.6%

4.12.1 Recommendation 15

- Item 45614: Change the item descriptor to clarify indication and include all required flaps or grafts.
    - The proposed item descriptor is as follows:
        - Eyelid reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required (Anaes.)(Assist.)
        - The Committee recommends a schedule fee similar to that of a full thickness flap for lip or eyelid reconstruction (Item 45671; $834.05)
- Item 45625: No change

4.12.2 Rationale for Recommendation 15

- Item 45614: Eyelid reconstruction is a highly complex and specialised procedure which should be performed by plastic surgeons or oculoplastic trained ophthalmologists. The Committee discussed that this item currently may be claimed by a different cohort of practitioners and may not always be interpreted correctly. The new wording adds clarity and enables clinicians to appropriately claim this item. The new caveat of including all flaps and grafts

avoids claiming of multiple items, which is in line with the principle of the complete medical service.

- Item 45625: The Committee recommends no change to this item as this procedure remains clinically relevant and adequately described by the item descriptor.

4.13 Miscellaneous reconstructive or restorative procedures of the head and neck

Table 14: Item introduction table for items 45653, 45656, 45665, 45668, 45671 and 45674

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45653	Rhinophyma, shaving of (Anaes.)	$356.35	111	$28,043	9.3%
45656	Composite graft (chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)	$502.25	671	$182,884	2.8%
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.)	$326.05	7,922	$1,943,016	3.0%
45668	Vermilionectomy, by surgical excision (Anaes.)	$326.05	298	$56,800	-3.7%
45671	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$834.05	305	$181,996	0.9%
45674	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$242.55	235	$38,417	3.6%

4.13.1 Recommendation 16

- Items 45653, 45656 and 45668: No change
- Item 45665: Change the descriptor to safeguard this item from cosmetic misuse.
    - The proposed item descriptor is as follows:
        - Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures, excluding eyelid wedge when performed in conjunction with a cosmetic eyelid procedure (Anaes.)

- Item 45671: Change item descriptor to clarify indication.
    - The proposed item descriptor is as follows:
        - Lip or eyelid reconstruction: single stage or first stage of a two stage flap reconstruction of a defect involving all three layers of tissue where the flap is switched from the opposing lip or eyelid respectively (Anaes.)(Assist)
- Item 45674: Change item descriptor to clarify indication.
    - The proposed item descriptor is as follows:
        - Lip or eyelid reconstruction: second stage of a two stage flap reconstruction, division of the pedicle and inset of flap and closure of the donor. (Anaes.)

4.13.2 Rationale for Recommendation 16

The rationale for this recommendation is based on reducing the risk of misuse and improving clarity of the Schedule.

- Item 45653: Shaving of rhinophyma remains an effective procedure as evidenced by the literature (18) and there is no indication to change this item.
- Item 45656: Chondromucosal and chondrocutaneous grafts continue to have a valid place in clinical practice and there is no indication to change this item.
- Item 45665: This recommendation is based on protecting Medicare against cosmetic misuse.
- Items 45671 and 45674: These changes are in line with modernising the terminology used in the Schedule to be less ambiguous as eponymous procedures are generally not useful for clarity. The inclusion in the descriptor to allow for a single stage procedure is in the interest of allowing for legitimate single stage procedures such as the Karapandzic flap of the lower lip.
- Item 45668: Although laser ablation of actinic cheilitis has now been proven to be effective (19) surgical vermillionectomy still has a place in clinical practice. The Committee noted that claims on this item are reducing and recommends no change.

4.14 Other general/skin procedures

Table 15: Item introduction table for item 45018, 45048 and 45560

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45018	Dermis, dermofat or fascia graft (excluding transfer of fat by injection), if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 40300 to 40351) (Anaes.) (Assist.)	$473.65	4,157	$699,340	-2.3%
45048	Lymphoedematous tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.)	$774.55	66	$28,473	29.7%
45560	Hair transplantation for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.)	$473.65	100	$50,760	-4.1%

4.14.1 Recommendation 17

- Item 45018: No change.
- Item 45048: No change; however, the Committee recommends that the field of lymphoedema is an area that may be worthy of an MSAC application for lymphovenous anastomosis.
- Item 45560: No change.

4.14.2 Rationale for Recommendation 17

This recommendation is around modernisation of the Schedule. The rationale for individual items is as follows:

- Item 45018: The Committee noted that historically there had been concerns with misuse of this item but observed the decline in use following the implementation of restrictions against its use in spinal surgery in November 2016 and were satisfied with the reduced potential for misuse. The Committee therefore recommends no change to the current item descriptor.

- Item 45048: The Committee considered this item to be clinically relevant and requiring no change, however it was noted that lymphoedema is a common condition amongst cancer survivors that poses significant impairment to quality of life to these patients. It is a difficult condition to treat and although surgical or liposuction removal of lymphoedematous tissue (item 45048) remains effective to a degree it cannot effect a cure. The Committee noted that lymphovenous anastomosis is showing promise in this area (20) (21) (22) (23) and recommends review in an MSAC process.
- Item 45560: The Committee recommends no change to this item as it remains clinically indicated with no evidence of misuse.

4.15 Lipoma or other subcutaneous tumours or cysts

The items in this area were not included within the scope of the Plastic and Reconstructive Surgery Clinical Committee review, however because of the involvement of plastic surgeons in the related Skin Services Review and because of the high usage of these items by Plastic and Reconstructive Surgery Specialists, the Committee sought to be allowed to consider a few of these items. The MBS Taskforce agreed to this process, which will hopefully serve to assist in the deliberations of the General Surgery Clinical Committee and also in the 12 month review of the Skin Services Review Implementation. The core recommendations are focussed on unforeseen consequences following implementation of the Skin Services Review recommendations.

Table 16: Item introduction table for items 31220, 31225 and 31345

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens	$214.55	3,822	$653,939	-1.4%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	excised are sent for histological examination (Anaes.)				
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	$381.30	747	$226,934	-0.9%
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and 50mm or more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diagnosis (Anaes.)	$210.95	9,011	$1,193,223	2.5%

4.15.1 Recommendation 18

- Create a new item to describe removal of a single lipoma or other subcutaneous tumour or cyst. The proposed item descriptors are as follows:
    - Proposed new descriptor for single tumour is as follows:
        - Tumour, lipoma or cyst, removal of single lesion by excision and suture, where removal is from subcutaneous tissue and the specimen excised is sent for histological examination (Anaes.)

The Committee recommends fee comparative to item number 31362 ($133.90)

- Item 31220: Change the descriptor to include lipomas.
    - The proposed item descriptor is as follows:

- Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and

(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and

(c) all of the specimens excised are sent for histological examination (Anaes.)

- Item 31225: Change the descriptor to include lipomas
    - Proposed item descriptor is as follows:
        - Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if:

          (a) the size of each lesion is not more than 10 mm in diameter; and

          (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and

          (c) each site of excision is closed by suture; and

          (d) all of the specimens excised are sent for histological examination (Anaes.)
- Item 31345: No change.
- Create a new item for large and difficult lipomas that require an assistant and usually general anaesthetic.
    - Proposed new item is as follows:
        - Lipoma, removal of by surgical excision or liposuction, where lesion is subcutaneous and more than 150mm in average diameter, or is submuscular, intramuscular or involving dissection of a named nerve or vessel and greater than 50mm, where the specimen is sent for histological confirmation of diagnosis (Anaes.)(Assist.)

The Committee recommends a schedule fee similar to that of treatment of pseudolipomas (Item 45584; $631.75)

4.15.2 Rationale for recommendation 18

This recommendation is centred on the need for consistency and transparency in claiming for these common procedures. The Skin Services Review played an important role in improving the coding of skin lesion excision items; however, prior to the Skin Services Review subcutaneous and cutaneous benign lesions were coded together. The Skin Services Review separated out cutaneous lesions and excision of lipomas and other subcutaneous tumours was inadvertently left unconsidered, which was an unintended consequence of the review. The recommendations above are proposed to address the gap which has existed since the implementation of the Skin Services Review in November 2016.

- Lipomas can cause discomfort and functional problems and may also require removal to exclude differential diagnoses. There are also rare congenital disorders in which multiple painful lipomas arise (Dercum's disease) (24). As lipomas can occur both singularly and in multiples, especially in syndromal conditions it is appropriate to have items specific for the excision of multiple lipomas as well as singular lipomas. This recommendation is based on ensuring the Schedule is robust and consistent with the Complete Medical Service concept. Finally, there are uncommon cases of very large lipomas for which it is appropriate to have a surgical assistant which has not previously been catered for in the Schedule. Careful wording of this new item descriptor is to enable appropriate selection and claiming of item numbers.
- Rationale for individual items is as follows:
    - New item for small single lipomas: This item is intended to fund the removal of small single subcutaneous lipomas and benign tumours that were previously part of the Schedule but were unintentionally excluded in the Skin Services Review. This item will allow for removal of single lipomas under 50mm in size, which are those not currently captured by item 31345.
    - Items 31220 and 31225: The modification of these items will address the previous unintentional exclusion of lipomas from the Schedule. In most cases lipomas will be removed in rooms with no requirement for general anaesthesia or intravenous sedation. In conditions such as Dercum's disease, where multiple painful lipomas require removal, use of anaesthetic is appropriate.
    - Item 31345: The Committee considers this item fit for purpose and requires no change.

- New item for large and difficult lipomas: Occasionally lipomas may become very large, up to 30cm or more in size, which makes removal challenging. They may develop deeply, in or below muscles of the trunk or limbs, or present in areas such as the supraclavicular fossa, or other anatomically challenging areas where dissection is difficult and an assistant is required. Such lipomas can cause compression syndromes and significant symptoms, therefore the Committee recommends inclusion of a new item to account for treatment of these large and difficult lipomas.

4.16 New items: Very extensive skin cancers

As per section 4.15, some skin services were unintentionally omitted from consideration during the Skin Services Review. The excision of very extensive skin cancers is one such area. This is an area of significance in Australia where skin cancer is a major health burden and it is important that these cases are coded appropriately in the Schedule to improve patients' access to care.

4.16.1 Recommendation 19

- Create new items to describe very extensive skin cancers.
  - The proposed item descriptors are as follows:
    - Malignant skin lesion (other than a malignant skin lesion covered by 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
      a) The lesion is excised from the head and neck; and
      b) The necessary excision diameter is greater than 50mm; and
      c) The excision involves at least two critical areas (eyelid, nose, ear, mouth)(Anaes.)(Assist.)
    - Malignant skin lesion (other than a malignant skin lesion covered by 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
      a) The lesion is excised from the head and neck; and
      b) The necessary excision diameter is greater than 70mm
      (Anaes.)(Assist.)
    - Malignant skin lesion (other than a malignant skin lesion covered by 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:

a) The lesion is excised from the trunk or limbs; and
b) The necessary excision diameter is greater than 120mm
(Anaes.)(Assist.)

4.16.2 Rationale for Recommendation 19

The rationale for this recommendation is centred on ensuring consistency and transparency in coding for these difficult procedures.

- Most skin cancers are small and well described by existing items in the Schedule, however plastic and reconstructive surgeons are sometimes required to treat very large, fungating skin cancers well outside the norm. There is no recognition of these tumour excisions in existing items and therefore no incentive for surgeons to undergo additional training and specialise in this area. The tight criteria around these new descriptors will ensure they clearly describe the procedure to enable appropriate selection and claiming of these items. The Committee considered that addition of these items is unlikely to have a significant impact on skin cancer billing overall and thoughtful formation of items will ensure appropriate recognition of this work and enable consistency of coding and billing in this area.

5. Recommendations: Breast Cancer Surgery and Reconstruction

About the Breast Cancer Surgery and Reconstruction Working Group

The Breast Cancer Surgery and Reconstruction Working Group was established in November 2017 to review all items relevant to breast cancer and breast reconstruction surgery. Although it is formally a working group under the Plastic and Reconstructive Surgery Clinical Committee, the items assigned to this Working Group pertain to both the work of the General Surgery Clinical Committee and the Plastic and Reconstructive Surgery Clinical Committee.

It was considered appropriate to review all the breast cancer related items as a whole as there is a significant amount of overlap between these two specialties. Breast cancer surgery and breast reconstruction can also be performed as one procedure.

The Working Group consists of six members whose names, positions/organisations and declared conflicts of interest are listed in Table 17.

Table 17: Breast Cancer Surgery and Reconstruction Working Group Members

Name	Position/organisation	Declared conflict of interest
Associate Professor Elisabeth Elder (Chair)	Clinical Associate Professor, University of Sydney; Chair, Oncoplastic Committee, BreastSurgANZ; Consultant Surgeon, Westmead Breast Cancer Institute; Council Member of Breast Surgeons International; Member of the Plastic and Reconstructive Surgery Clinical Committee	Claims in-scope MBS items Holds shares in a private hospital
Professor Christobel Saunders	Professor of Surgical Oncology, The University of Western Australia; President of BreastSurgANZ; Consultant Surgeon, St John of God Hospital	Claims in-scope MBS items
Dr Nicola Dean	Head of Plastic & Reconstructive Surgery Services at Flinders Medical Centre; Honorary Secretary, Australian Society of Plastic Surgeons; Chair of the Plastic and Reconstructive Surgery Clinical Committee	Claims in-scope MBS items

Name	Position/organisation	Declared conflict of interest
Dr Dan Kennedy	Honorary Treasurer, Australian Society of Plastic Surgeons; Consultant Plastic Surgeon, Mater Adults Hospital; Member of the Australian Society of Plastic Surgeons, the Australasian Society of Aesthetic Plastic Surgeons and the International Society of Aesthetic Plastic Surgeons; Member of the Plastic and Reconstructive Surgery Clinical Committee	Claims in-scope MBS items Clinical trainer and educator for Galderma Australia Pty. Ltd Holds shares in a private hospital
Ms Chris Horsell	Consumer Representative; Breast cancer survivor; Board Director, Reclaim Your Curves; Member of the Plastic and Reconstructive Surgery Clinical Committee	None
Ms Geraldine Robertson	Consumer Representative; Breast cancer survivor; Breast Cancer Network Australia	None

Areas of responsibility of the Working Group

A number of items relating to breast surgery have already been considered as part of a review of the Medicare Claims Review Panel (MCRP) and associated plastic and reconstructive surgery items. These items will be amended on 1 November 2018 to safeguard them from cosmetic misuse and are outside the scope of this Working Group. The relevant items are outlined in Appendix E.

Introduction and general recommendation for bilateral items

The Working Group has made recommendations for each of the items in scope as well as one broader recommendation that applies to multiple items. The latter involves the introduction of new bilateral versions of existing items where appropriate. These additions are recommended on an item-by-item basis in the relevant sections below, but their rationale is broadly similar. The Working Group offers an overall rationale for bilateral items:

- Breasts are paired structures and it is logical to have bilateral item numbers.
- Bilateral mastectomy (and consequently reconstruction) is increasingly common due to factors such as increased genetic testing for the BRCA 1 and 2 gene mutations, which confer a high risk for breast cancer.

- Fewer items need to be claimed per procedure, which adheres to the principle of a complete medical service.
- Having bilateral items more accurately reflects patterns of disease, which is helpful in understanding national breast surgery and reconstruction rates and patterns.

Bilateral items are generally introduced with a schedule fee at 150 per cent of the unilateral item, based on claiming the unilateral item twice in accordance with the multiple operation rule. However the Working Group recommended that consideration be given to setting a fee at 175 per cent of the unilateral item similar to some orthopaedic items, for example, items 49318 (unilateral total hip replacement; fee: $1,317.80) and 49319 (bilateral total hip replacement; fee: $2,315.30). The Working Group believes that mastectomy and reconstructive procedures are not well reimbursed considering the time and complexity, especially for autologous breast reconstruction procedures, which can take up to 10 hours, and the surgeons are additionally responsible for managing the aftercare of patients. The Working Group notes there may be a disincentive to perform bilateral procedures in one episode, despite benefits for the patient, as the surgeon is reimbursed less and does not have the advantage of increased efficiency.

The item-level recommendations are described below. A summary list of recommendations can be found in Appendix D, and in the consumer summary tables in Appendix A and Appendix C.

The changes focus on encouraging best practice, modernising the MBS to reflect contemporary practice, and ensuring that MBS services provide value for the patient and the healthcare system.

5.1 Sentinel lymph node biopsy (axilla and internal mammary chain)

Table 18: Item introduction table for items 30299, 30300, 30302 and 30303

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.)	$637.45	3,337	$768,592	2%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30300	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.)	$764.90	5,163	$2,595,892	7%
30302	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.)	$509.95	313	$55,999	-5%
30303	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.)	$611.85	140	$30,913	-4%

5.1.1 Recommendation 20 – Sentinel lymph node biopsy (axilla)

- Items 30299, 30300, 30302 and 30303: Consolidate into a single item covering use of preoperative lymphoscintigraphy and/or lymphotropic dye injection, in any axilla level.
    - Proposed item descriptor is as follows:
        - Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in an axilla, using preoperative lymphoscintigraphy and/or lymphotropic dye injection (Anaes.)(Assist.)

5.1.2 Rationale for Recommendation 20 – Sentinel lymph node biopsy (axilla)

This recommendation focuses on maintaining access to best-practice health services, as well as ensuring value for the individual patient and the health system. It is based on the following:

As sentinel lymph node biopsies are now standard of care, the technical challenge of removing a sentinel lymph node from level I as opposed to level II or III of the axilla is not substantially different in most cases.

The Working Group initially recommended that items 30299 and 30300, using preoperative lymphoscintigraphy and lymphotropic dye injection, be replaced with a single item number.

Similarly items 30302 and 30303, using lymphotropic dye injection, could be replaced with a single item number. This recommendation was to encourage best practice by ensuring that there was no financial incentive to perform sentinel lymph node biopsy with lymphotropic dye injection alone as this practice is less accurate than dual-agent mapping (using lymphoscintigraphy with lymphotropic dye).

After discussion with the Oncology Clinical Committee the Plastic and Reconstructive Surgery Clinical Committee agreed that retaining separate items for single-agent mapping with lymphotropic dye unnecessary. In order to simplify the schedule, the Committee therefore recommended creating one item using the phrase "and/or," rather than listing separate items for dual-agent and single-agent mapping. Retaining the word "or" allows flexibility for the rare situations in which lymphoscintigraphy may be contraindicated. The Committee agreed that single-agent mapping should be discouraged.

5.1.3 Recommendation 21 – Sentinel lymph node biopsy (internal mammary chain)

- Introduce a new item for sentinel lymph node biopsy of the internal mammary chain
    - The proposed new item descriptor is as follows:
        - Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection along internal mammary chain (Anaes.) (Assist.)

The Working Group recommends this item have a schedule fee equivalent to that of item 30300 as amended.

5.1.4 Rationale for Recommendation 21 – Sentinel lymph node biopsy (internal mammary chain)

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Internal mammary sentinel lymph node biopsy (IM-SLNB) is a minimally invasive technique for the evaluation of the status of internal mammary sentinel lymph nodes with high safety and feasibility. In some cases, accurate staging cannot be achieved through biopsy of the axillary sentinel lymph node alone, which might lead to under-staging and under-treatment. Identification of metastases though IM-SLNB has the potential to alter the stage and adjuvant therapy of breast cancer patients (25). IM-SLNB can enable more accurate lymph node staging and improve the decision making of the adjuvant radiotherapy of the IMLN, and even adjuvant systemic therapy in some cases (26) (27).

The Working Group considered that this procedure would be done in a small subset of patients receiving a sentinel lymph node biopsy in the axilla. The service is currently claimed

under a range of item numbers, commonly item 38418 (Thoracotomy, exploratory, with or without biopsy; schedule fee: $958.40). That is not the intended use of item 38418 and the Working Group considered it would be appropriate to introduce a new item.

The schedule fee is recommended to be equivalent to that of amended item 30300 as the complexity of the service is similar to sentinel lymph node biopsy of the axilla.

5.2 Excision of lymph nodes

Table 19: Item introduction table for items 30332, 30335 and 30336

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)	$346.75	1,142	$187,974	4%
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.)	$866.85	389	$221,586	-2%
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)	$1,040.25	2,700	$2,021,964	-2%

5.2.1 Recommendation 22 – Excision of lymph nodes

- Item 30332: Amend the descriptor to remove the specification that it be used for sampling
    - The proposed new descriptor is as follows:
        - Lymph nodes of axilla, limited excision of (Anaes.) (Assist.)
- Item 30335: Delete
- Item 30336: Amend the descriptor to remove the levels of axilla
    - The proposed new descriptor is as follows:
        - Lymph nodes of axilla, complete excision of (Anaes.) (Assist.)

5.2.2 Rationale for Recommendation 22 – Excision of lymph nodes

This recommendation focuses on simplifying the MBS. It is based on the following:

The Working Group considered current clinical practice would be to perform either a limited excision or a complete excision and that the items should reflect this.

The Working Group discussed that item 30335 was obsolete as lymph node excisions to level I could be regarded as limited excisions and covered by item 30332 or could be considered complete excisions and covered by item 30336.

5.3 Excision or biopsy of breast lesions and tumours

Table 20: Item introduction table for items 31500, 31503, 31506, 31509, 31512, 31515, 31516, 31539 and 31545

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.)	$260.05	1,881	$327,572	-3%
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.)	$346.75	624	$150,286	1%
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)	$390.10	2,627	$660,160	-1%
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.)	$346.75	58	$11,522	-4%
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.)	$650.15	7,960	$2,733,491	3%
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.)	$436.15	1,467	$429,174	1%
31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an Intrabeam® device) is performed concurrently, if the requirements of	$736.05	8	$4,552	-

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	item 15900 are met for the patient (Anaes.) (Assist.)				
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.)	$398.80	-	$-	-
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.)	$595.65	-	$-	-

5.3.1 Recommendation 23 – Breast lesions and tumours

- Items 31500, 31503, 31506, 31509, 31512, 31515 and 31516: No change
- Items 31539 and 31545: Delete

5.3.2 Rationale for Recommendation 23 – Breast lesions and tumours

This recommendation focuses on simplifying the MBS. It is based on the following:

Items 31539 and 31545: The Working Group noted that these items had not been used at all in recent years and considered they were no longer consistent with current clinical practice.

The Working Group considered that the other items all appropriately reflect current clinical practice.

5.3.3 Recommendation 24 – Oncoplastic breast surgery

- Create one new item for Level 1 oncoplastic breast surgery

- Proposed new descriptor is as follows:
  - Breast, malignant tumour, complete local excision of, with simultaneous reshaping of the breast parenchyma using techniques such as round block or rotation flaps (Anaes.)(Assist.)

The Working Group recommends a schedule fee between item 31512 and the fee for the Level 2 oncoplastic breast surgery item below.

- Create one new item for Level 2 oncoplastic breast surgery
  - The proposed new descriptor is as follows:
    - Breast, malignant tumour, complete local excision of, with simultaneous breast reduction including repositioning of the nipple (Anaes.)(Assist.)

The Working Group recommends that this item have a schedule fee that combines those of items 31512 ($650.15) and 45520 ($900.45), in accordance with the multiple operations rule.

5.3.4 Rationale for Recommendation 24– Oncoplastic breast surgery

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Oncoplastic breast surgery (OBS) is defined as breast cancer surgery focusing on optimising oncologic and aesthetic outcomes, and is increasingly being utilised in clinical practice. The aim of OBS techniques is to allow resection of larger volumes of breast tissue followed by reshaping of the breast to obtain a normal shaped breast without deformity.

OBS has been shown to improve aesthetic outcomes (28) while maintaining oncological safety (29).

OBS techniques extend the indication for breast conserving surgery allowing a proportion of patients to avoid mastectomy. It has also been shown to reduce re-excision rates while treating patients with larger cancers (30).

Currently there are no specific item numbers for these procedures and services are claimed using a combination of item 31512 (complete local excision) and items 45520/45522 (breast reduction) or potentially other flap items.

The Working Group considers that the current items do not adequately reflect the techniques presently used in modern breast surgery practice, and it would be appropriate to introduce two new items to cover Level 1 and Level 2 OBS techniques. Level 1 OBS

techniques use simple glandular flaps while Level 2 OBS techniques apply breast reduction and/or mastopexy techniques to reshape the breast (31).

Co-claiming data shows that items 45520 and 45522 are claimed with 31512 in about 10 per cent of all episodes where complete local excisions are performed. Item 31512 is also claimed with various flap items in a number of different combinations.

5.4 Mastectomy

Table 21: Item introduction table for items 31519, 31524 and 31525

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
31519	BREAST, total mastectomy (H) (Anaes.) (Assist.)	$736.05	3,739	$1,350,122	0%
31524	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)	$1,040.25	2,660	$1,387,104	10%
31525	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	$520.00	1,716	$508,840	5%

5.4.1 Recommendation 25 – Mastectomy

- Item 31519: Amend this item to clarify that it is for unilateral procedures
    - The proposed new descriptor is as follows:
        - Breast, total mastectomy (unilateral) (Anaes.) (Assist.)
- Item 31519A: Introduce a new item for bilateral total mastectomy:
    - The proposed new descriptor is as follows:
        - Breast, total mastectomy (bilateral) (Anaes.) (Assist.)
- Item 31525: Amend this item to clarify gynecomastia and that it is for unilateral procedures
    - The proposed new descriptor is as follows:
        - Breast, mastectomy for gynaecomastia (unilateral), with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies, and is not applicable when breast enlargement is due to obesity and is

proportionate to body habitus. Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.) (Assist.)

- Item 31525B: Introduce a new item for bilateral mastectomy for gynaecomastia:
    - The proposed new descriptor is as follows:
        - Breast, mastectomy for gynaecomastia (bilateral), with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies, and is not applicable when breast enlargement is due to obesity and is proportionate to body habitus. Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.) (Assist.)

5.4.2 Rationale for Recommendation 25 – Mastectomy

This recommendation focuses on clarifying the MBS. It is based on the following:

Items 31519 and 31519A: The Working Group considered this item appropriate but recommended the creation of a new item for bilateral procedures.

Item 31525: The Working Group recommended amending the descriptor to clarify gynecomastia so it will be clear when this item can be claimed and to reduce the potential for misuse. An additional change is recommended to amend the spelling of 'gynecomastia' to 'gynaecomastia'.

5.4.3 Recommendation 26 – Nipple sparing mastectomy and skin sparing mastectomy

- Item 31524: Replace this item with new items for nipple sparing mastectomy and skin sparing mastectomy
- Create two new items for skin sparing mastectomy, one for unilateral procedures and one for bilateral procedures
    - The proposed unilateral descriptor is as follows:
        - Breast, skin sparing mastectomy (unilateral) (Anaes.) (Assist.)

The Working Group recommends a schedule fee similar to item 31524 for this unilateral item.

- The proposed bilateral descriptor is as follows:

- Breast, skin sparing mastectomy (bilateral) (Anaes.) (Assist.)

- Create two new items for nipple sparing mastectomy, one for unilateral procedures and one for bilateral procedures
    - The proposed unilateral descriptor is as follows:
        - Breast, nipple sparing mastectomy (unilateral) (Anaes.) (Assist.)

The Working Group recommends a schedule fee slightly higher than item 31524 for the unilateral item due to the additional difficulty of performing this procedure.

- The proposed bilateral descriptor is as follows:
    - Breast, nipple sparing mastectomy (bilateral) (Anaes.) (Assist.)

5.4.4 Rationale for Recommendation 26 – Nipple sparing mastectomy and skin sparing mastectomy

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Skin sparing mastectomy (SSM) is a type of mastectomy that involves the removal of all breast tissue and glands but leaves the skin of the breast mostly intact. Nipple sparing mastectomy (NSM) is a type of mastectomy in which the breast tissue is removed, but surgeons preserve the entire breast skin "envelope" including the nipple areola complex. Typically, breast reconstruction is performed immediately.

The option of SSM or NSM allows the breast skin envelope to be retained and used in immediate reconstruction performed with implant or autologous tissue. Use of the patient's existing breast skin allows reconstruction to be performed with a more natural look and minimal scarring (32) (33) (34).

SSM and NSM have been shown to be oncologically safe (35) (36) with no statistically significant difference in survival rates and recurrence rates to other types of mastectomy (37).

NSM was in the past known as "subcutaneous mastectomy". In the 1970s, subcutaneous mastectomy was usually performed for benign disease, breast cancer prevention and less frequently for cancer. The modern term "nipple-sparing mastectomy" now refers to a more radical surgical removal of breast tissue than was carried out during the subcutaneous mastectomy era.

Although currently SSM and NSM are performed using item 31524 for subcutaneous mastectomy, the Working Group considers that the term "subcutaneous mastectomy" does

not adequately reflect the techniques presently used in modern breast surgery practice, and it would be appropriate to introduce new items to cover SSM and NSM.

5.5 Other breast procedures

Table 22: Item introduction table for items 31551, 31554, 31557, 31560, 31563 and 31566

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.)	$216.75	794	$108,665	2%
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)	$433.50	547	$166,378	0%
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)	$346.75	211	$49,429	-1%
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)	$346.75	357	$70,660	7%
31563	INVERTED NIPPLE, surgical eversion of (Anaes.)	$259.75	494	$75,626	1%
31566	ACCESSORY NIPPLE, excision of (Anaes.)	$129.95	94	$8,435	-4%

5.5.1 Recommendation 27 – Other breast procedures

- Items 31551, 31554, 31557, 31560 and 31566: No change
- Item 31563: Amend the descriptor to include flap repair
    - The proposed new descriptor is as follows:
        - INVERTED NIPPLE, surgical eversion of, with or without flap repair, where the nipple cannot be everted manually (Anaes.)

5.5.2 Rationale for Recommendation 27 – Other breast procedures

This recommendation focuses on clarifying the MBS. It is based on the following:

The Working Group considered that items 31551 to 31560 and 31566 appropriately describe current clinical practice.

Item 31563: The Working Group recommended that the descriptor should clarify that if flap repair is performed, it is included as part of this service, and should not be co-claimed. The Working Group also discussed that inverted nipples are a common occurrence which do not always require surgical treatment and felt that the amendment would clarify when it was appropriate to perform surgical eversion of an inverted nipple.

5.6 Flap revision

Table 23: Item introduction table for items 45497, 45498 and 45499

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45497	FLAP, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - complete revision of, by liposuction (Anaes.)	$324.95	225	$27,394	3%
45498	FLAP, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - first stage (Anaes.)	$261.55	33	$4,012	13%
45499	FLAP, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - second stage (Anaes.)	$195.00	9	$631	35%

5.6.1 Recommendation 28 – Flap revision

- Items 45497, 45498 and 45499: Consolidate into one new item.
    - The proposed new descriptor is as follows:
        - FLAP, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction – revision of, by liposuction (Anaes.)

5.6.2 Rationale for Recommendation 28 – Flap revision

This recommendation focuses on simplifying and modernising the MBS and encouraging appropriate use of items. It is based on the following.

The recommendation to consolidate items 45497, 45498 and 45499 simplifies the MBS and also allows for instances where it is unknown whether one or two revisions will be required.

5.7 Breast reconstruction using prostheses

Table 24: Item introduction table for items 45527, 45539 and 45542

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.)	$741.65	631	$200,890	11%
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)	$1,071.20	1,914	$1,162,449	4%
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)	$613.40	1,562	$509,309	3%

5.7.1 Recommendation 29 – Breast reconstruction using prostheses

- Item 45527: Amend the descriptor and the fee
    - The proposed new descriptor is as follows:
        - Breast reconstruction (unilateral), following mastectomy, using permanent prosthesis (Anaes.) (Assist.)

The Working Group noted that this item will be amended as part of another review (see Appendix E) and agreed with the proposed wording change. The Working Group recommended that the fee for this item should be comparable with the fee for item 45539 as the complexity of these procedures is broadly similar.

- Item 45527A: Introduce a new item for bilateral procedures:
    - The proposed new descriptor is as follows:
        - Breast reconstruction (bilateral), following mastectomy, using permanent prostheses (Anaes.) (Assist.)
- Item 45539: Amend the fee

The Working Group recommended that the fee for this item should be consolidated with the fee for item 45527 as the complexity of these procedures is broadly similar.

- Item 45539A: Introduce a new item for bilateral procedures:
    - The proposed new descriptor is as follows:
        - Breast reconstruction (bilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)
- Item 45542: No change
- Item 45542A: Introduce a new item for bilateral procedures:
    - The proposed new descriptor is as follows:
        - Breast reconstruction (bilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)

- Item 45542B: Introduce a new item for breast reconstruction, revision of, for rotation and migration of permanent prosthesis.
    - The proposed new descriptor is as follows:
        - Revision of breast prosthesis pocket, where breast prosthesis or tissue expander has been placed for the purpose of breast reconstruction in the context of breast cancer or for developmental breast abnormality and where the prosthesis or tissue expander has migrated or rotated from its intended position or orientation and the existing prosthesis is used.

5.7.2 Rationale for Recommendation 29 – Breast reconstruction using prostheses

This recommendation focuses on clarifying the MBS. It is based on the following:

Item 45527: The Working Group considered that the term “augmentation mammoplasty” does not accurately describe the service being performed and it would be better to describe the service as “breast reconstruction”. This would also maintain consistency with the other breast reconstruction items.

Items 45539 and 45542: The Working Group considered that these items were still relevant and appropriately described clinical practice.

Items 45527 and 45539: The Working Group recommended the schedule fees for items 45527 and 45539 should be similar as these procedures have a similar level of complexity. It was noted that the higher fee for item 45539 took into account additional attendances for expansion injections. However the Working Group discussed that the number of expansions required after insertion of a tissue expander has decreased with the trend of leaving more of the native breast skin during the mastectomy and therefore being able to expand the expander to a significant degree during the first operation. In some cases, an air expander is used instead of a saline expander, so there is no requirement for postoperative visits for expansion.

It was also discussed that reconstruction using a permanent prosthesis could be more difficult and time consuming than inserting a tissue expander, especially in a unilateral procedure when the shape of the implant needs to be matched to the contralateral breast which often includes trial with several gel implant sizers before choosing the permanent implant.

5.8 Breast reconstruction using autologous flaps

Table 25: Item introduction table for items 45530, 45533 and 45536

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45530	Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies (H) (Anaes.) (Assist.)	$1,099.40	479	$330,012	-4%
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.)	$1,245.10	73	$63,016	14%
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.)	$457.85	5	$1,047	-7%

5.8.1 Recommendation 30 – Breast reconstruction using autologous flaps

- Item 45530: Amend the descriptor
    - The proposed new descriptor is as follows:
        - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS (unilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies (Anaes.) (Assist.)

The Working Group recommends no change to the current schedule fee.

- Item 45530A: Introduce a new item for bilateral breast reconstruction:
    - The proposed new descriptor is as follows:
        - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS (bilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies (Anaes.) (Assist.)
- Item 45533: Delete item and replace with two new items for perforator flaps, one for reconstruction of a partial mastectomy defect and the other for preparation for microsurgical transfer of a free flap
- Item 45533A:
    - The proposed new descriptor for correction of partial mastectomy defects is as follows:
        - PERFORATOR FLAP, such as a thoracodorsal artery perforator (TDAP) flap or lateral intercostal artery perforator (LICAP) flap or similar, raising on a named source vessel, for reconstruction of a partial mastectomy defect (Anaes.)(Assist.)

The Working Group considers the complexity of this procedure would be between a direct flap repair (item 45209; fee: $473.75) and a neurovascular island flap (item 45563; fee: $1,099.40) and recommends a schedule fee halfway between these two items.

- Item 45533B:
    - The proposed new descriptor for preparation for microsurgical transfer of a free flap is as follows:

- PERFORATOR FLAP, such as a deep inferior epigastric perforator (DIEP) flap or similar, raising in preparation for microsurgical transfer of a free flap for post-mastectomy breast reconstruction (Anaes.)(Assist.)

The Working Group recommends a schedule fee closer to that of item 45563 due to the additional difficulty of this procedure.

- Item 45536: Delete item
- Introduce a new item for revision of post-mastectomy breast reconstruction procedures:
    - The proposed new descriptor is as follows:
        - Revision of post-mastectomy breast reconstruction (Anaes.) (Assist.)

The Working Group recommends a schedule fee slightly higher than item 45518 for scar revision for this item.

5.8.2 Rationale for Recommendation 30 – Breast reconstruction using autologous flaps

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Item 45530: The Working Group considered that the current descriptor emphasises one type of reconstruction over another. As a wider variety of reconstructive flaps are being used, a more generic descriptor is appropriate.

Item 45533: The Working Group discussed that this procedure dates back to an era prior to microvascular reconstruction and is now redundant. The Working Group proposes that new items should be introduced for the modern equivalent of this procedure, which is preparation of a perforator flap.

Perforator flaps can be used after both lumpectomy and mastectomy: as part of a volume replacement technique to reshape the breast in the context of breast conserving surgery or in preparation for a microsurgical transfer of a free flap post-mastectomy (38) (39). The Working Group considered that two new items for these different scenarios would be appropriate.

Generally, volume replacement techniques can maintain the volume/shape of the breast, avoiding contralateral surgery to reach symmetry. However, these techniques can be more complex procedures that are sometimes associated with donor site morbidity. Use of a

perforator flap has the benefit of sparing the underlying muscles and their main blood supply, reducing the risk of donor site or flap morbidity (40).

The Working Group also discussed that the items should not define use of particular flaps but should include examples to assist providers. There are many patient factors that affect choice of flaps and donor site, and this should be a matter for clinical judgment.

Item 45536: As with item 45533, the Working Group discussed that this procedure was now obsolete and the item could be removed.

The Working Group discussed that in some instances, it was difficult to achieve an acceptable result following breast reconstruction and sometimes a minor procedure would be needed to refine the original procedure. This could include adjusting the contour of the reconstruction or its placement on the chest wall or other similar intervention. There are currently no items specific to this but the service could be claimed under item 45518 (revision of a scar more than 7cm in length; schedule fee: $225.70). The Working Group considered that it would appropriate to introduce a new item specifically for revision of breast reconstruction procedures.

5.8.3 Recommendation 31 – Microsurgical breast reconstruction

- Introduce new items for microsurgical breast reconstruction for single surgeons
    - The proposed unilateral descriptor is as follows:
        - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, SINGLE SURGEON (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomosis of artery and one or more veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies (Anaes.) (Assist.)

The Working Group recommends a schedule fee based on the combination of items currently claimed for this procedure, above the fee for the principal surgeon in the conjoint version of the same procedure (item 45564; fee: $2,546.30).

- The proposed bilateral descriptor is as follows:
    - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, SINGLE SURGEON (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomoses of arteries and veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which

items 30165, 30168, 30171, 30174 or 30177 or 30179 applies (Anaes.) (Assist.)

- Introduce new items for microsurgical breast reconstruction for conjoint surgery
    - The proposed descriptor for principal surgeon (unilateral) is as follows:
        - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, CONJOINT SURGERY (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomosis of artery and one or more veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies – conjoint surgery, principal specialist surgeon (Anaes.) (Assist.)

The Working Group recommends a schedule fee equivalent to that of item 45564 ($2,564.30) as this item would currently be used for this service.

- The proposed descriptor for conjoint surgeon (unilateral) is as follows:
    - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, CONJOINT SURGERY (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomosis of artery and one or more veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies – conjoint surgery, conjoint specialist surgeon (Assist.)

The Working Group recommends a schedule fee equivalent to that of item 45565 ($1,909.80) as this item would currently be used for this service.

- The proposed descriptor for principal surgeon (bilateral) is as follows:
    - POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, CONJOINT SURGERY (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomosis of artery and one or more veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174, 30177 or 30179 applies – conjoint surgery, principal specialist surgeon. (Anaes.) (Assist.)
- The proposed descriptor for conjoint surgeon (bilateral) is as follows:

- POST-MASTECTOMY BREAST RECONSTRUCTION, AUTOLOGOUS, CONJOINT SURGERY (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer, including anastomoses of arteries and veins, including repair of secondary skin defect excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 or 30179 applies conjoint surgery, conjoint specialist surgeon (Assist.)

5.8.4 Rationale for Recommendation 31 – Microsurgical breast reconstruction

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Microsurgical breast reconstruction has evolved over the past 30 years and has become more widely used in clinical practice (41). Unlike other autologous reconstruction techniques (like the TRAM flap), these perforator flap techniques preserve the patient's underlying musculature. The tissue is then transplanted to the patient's chest and reconnected using microsurgery (42). Preserving underlying muscles lessens postoperative discomfort making the recovery easier and shorter, and also enables the patient to maintain muscle strength long-term (43).

There are currently no items specific to microsurgical breast reconstruction and it is performed using a combination of general microvascular flap items, for example, 45562 (free transfer of tissue; fee: $1,099.40) and 45504/45505 (microvascular anastomosis of vein/artery using microsurgical techniques; fee: $1,774.70). The Working Group considered that microsurgical breast reconstruction is a distinct service with its own particular set of techniques and enough case volume to warrant item numbers independent of general microvascular free flaps. The Working Group recommends that specific items should be introduced to cover this important service.

Due to the complexity of microsurgical breast reconstruction, it is often appropriate for there to be two surgeons operating on the patient. This has benefits in patients by reducing operative time and reducing length of stay in hospitals for both unilateral and bilateral reconstruction (44). In light of this, the Working Group considered that it would also be appropriate to introduce new items for conjoint surgery.

5.9 Nipple reconstruction

Table 26: Item introduction table for items 45545 and 45546

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	$622.55	1,140	$388,817	-1%
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$197.85	442	$59,303	0%

5.9.1 Recommendation 32 – Nipple reconstruction

- Item 45545: No change.
- Item 45546: Nurse Practitioners should be provided access to item 45546.

5.9.2 Rationale for Recommendation 32 – Nipple reconstruction

This recommendation focuses on clarifying the MBS. It is based on the following:

The Working Group considered that these items were still relevant and appropriately described clinical practice.

- The Plastic and Reconstructive Surgery Clinical Committee consider it appropriate that access to item 45546 is provided to Nurse Practitioners.

5.10 Lower pole coverage

Table 27: Item introduction table for new items

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
New item	LOWER POLE COVERAGE OF RECONSTRUCTIVE BREAST PROSTHESIS, following mastectomy, using oblique turnover flaps or autologous dermal flaps, to be used in combination with 45527, 45539, 45542, or [new skin-sparing mastectomy items] (Anaes.) (Assist.)				

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
New item	LOWER POLE COVERAGE OF RECONSTRUCTIVE BREAST PROSTHESIS, following mastectomy, using allograft or synthetic products (Anaes.) (Assist.)				

5.10.1 Recommendation 33 – Lower pole coverage

- Introduce a new item for lower pole coverage using autologous flaps:
    - The proposed new descriptor is as follows:
        - LOWER POLE COVERAGE OF RECONSTRUCTIVE BREAST PROSTHESIS, following mastectomy, using muscle or fascia turnover flap or autologous dermal flaps, to be used in combination with 45527, 45539, 45542, or [new skin-sparing /nipple-sparing mastectomy items] (Anaes.) (Assist.)

The Working Group recommends a schedule fee similar to item 45203 ($406.05) for complicated or large single stage local flap repair.

- Introduce a new item for lower pole coverage using allografts or synthetic products:
    - The proposed new descriptor is as follows:
        - LOWER POLE COVERAGE OR COMPLETE IMPLANT COVERAGE OF RECONSTRUCTIVE BREAST PROSTHESIS, following mastectomy, using allograft or synthetic products (Anaes.) (Assist.)

The Working Group recommends a schedule fee similar to item 45203 ($406.05) for complicated or large single stage local flap repair.

5.10.2 Rationale for Recommendation 33 – Lower pole coverage

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Coverage of the lower part of a reconstructive breast implant with an additional layer of tissue is suggested to result in improved outcomes, with less need for revision of implant-based breast reconstruction. The procedure can be done by using autologous flaps or by using allograft or synthetic products.

The Working Group discussed that lower pole coverage services may be claimed under flaps items currently as there is not a specific item number for this service. The Working Group considered that it would be appropriate to create new items for lower pole coverage.

The Working Group understands that lower pole coverage using allografts or synthetic products will likely require MSAC review, and wishes to note its support for the introduction of such a new item.

5.11 Autologous fat grafting (lipofilling)

Table 28: Item introduction table for new items

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
New item	Autologous fat grafting for defect resulting from excision of a breast malignancy or for defect post-mastectomy or for developmental abnormality				

5.11.1 Recommendation 34 – Autologous fat grafting

- Introduce a new item for autologous fat grafting
    - The proposed new descriptor is as follows:
        - Autologous fat grafting for defect resulting from excision of a breast malignancy or for defect post-mastectomy or for developmental abnormality (Anaes.) (Assist.)

5.11.2 Rationale for Recommendation 34 – Autologous fat grafting

This recommendation focuses on ensuring that the MBS supports patient access to modern clinical procedures. It is based on the following:

Autologous fat grafting, also known as lipofilling, uses the patient's own fat to correct contour defects, by reinjecting adipocytes after processing. Fat grafting can be used to repair defects from breast reconstruction or breast conservation surgery, reducing the need for revision surgery in suitable patients. It can also be used to correct contour defects relating to developmental abnormalities of the breast.

This procedure is currently performed in clinical practice but there is no specific item for it. The Working Group considered it would be appropriate to add a new item specifically for fat grafting as this is a valuable service for the reconstructive process.

The Working Group understands that this procedure will likely require MSAC review, and wishes to note its support for the introduction of such a new item.

6. Recommendations: Burns

Introduction to Modern Burns Surgery

The concept of early excision and skin grafting for burns was introduced by Zora Janseokovic in 1970 (45), and this idea that excision of the acute burn reducing mortality has been validated again and again by subsequent researchers. A meta-analysis in 2006 (46) showed that in burns without an inhalational component, risk of death is reduced in those with early excision and closure to almost one third of that in those who do not have early excision and closure (47). The mainstay of closure of defects following burn excision has been autologous skin graft up until the last 15 to 20 years. The problem for patients with large burns is that there is insufficient unburned skin to use as autologous donor sites. This has meant that, until recently, these patients have been unable to access the benefits of early excision and closure of wounds and continued to have a high mortality rate.

However, the practice of burns surgery has changed significantly with the advance of technology, which has produced dermal analogues and bio-engineered skin substitutes (48). This has changed not only the nature of individual procedures, but also the pattern of treatment (49). In modern burns practice, patients will often have a complete burn excision and application of skin substitutes as the first stage of a two or three stage course of surgical procedures (47) (50). The de-lamination of the skin substitute and delayed skin grafting often constitute these later procedures. The advent of skin substitutes and this type of treatment allows for complete burn excision and coverage at the first operation, where previously this was not possible in many large burns, due to lack of autologous skin graft donor sites (51) (52). This modern approach using skin substitutes is now extending the benefits of early excision and closure to those very extensive burns patients, who could not previously benefit (52) (53).

Another major shift in the way that burns are treated in modern times is that dual surgeon teams are more common. This is because it has been established that reduced duration of surgery improves patient survival and outcome and that two surgeons can perform a procedure more quickly than one. The two surgeon approach also facilitates early excision and closure in those who it was not possible to treat this way in previous decades.

Drivers of Recommendations in the Burns Section

These two factors in modern day burns surgery (dual surgeon and incorporating skin substitutes into early closure methods) have predominantly driven the recommended changes to this section of the Plastic and Reconstructive Surgery Clinical Committee report. In addition, the Committee has born in mind the principles of the Principles and Rules Committee (PRC) and have devised revisions that are likely to facilitate "Complete Medical Services". This is a significant shift as the items were originally written to be used in a modular way. In treatments that are commonly multi-surgeon and multi-stage with a very high degree of variation between patients (based on total body surface area burned) it has been challenging to meet the obligation to follow these principles at the same time as maintaining accuracy of coding and incorporation of modern practice, whilst retaining clarity.

Model for Burns Excision and Closure Item Numbers

Five models were considered for the revision of the excision and closure of burns item numbers:

1) Maintain existing items in a standard list and make amendments, with addition of multiple new items for each combination of practice (e.g. debridement of burn plus autologous skin graft, debridement of burn plus 10 per cent autologous skin graft and 10 per cent skin substitute etc). This model was rejected as it would result in an extremely excessive number of items or would result in the necessity to claim multiple items with every procedure.

2) A bundled payment system. This suggestion was rejected as the variability and unpredictability of burns patients would mean that it would be impossible to achieve any fairness within the system. Burns patients are typically very complex and individualisation of treatment is required. The model for coding and billing should be fit for purpose in terms of recognising this.

3) A time-based system. This suggestion was rejected as it was felt that it would be appropriate to have some consistency with other surgical specialties. Currently, only anaesthesia uses a time-based system and the nature of surgery is such that it is not only the time spent operating that should be remunerated. It would also be intrinsically inappropriate to build in a disincentive to short operative times when it is known that this is an important factor for patient outcome.

4) A system of tables where burns excision is separated from burns closure. This option was acceptable to burns surgeons, the Committee and in line with PRC principles.

5) A system of tables, as above, but with a modifier, to provide extra funding for burns involving hands, face and anterior neck. The addition of this modifier to the model reduces the number of items required substantially but would mean that surgeons would have to claim more items per procedure and would be likely to exceed the "three item rule" in many cases. This is acceptable to burns surgeons and the Committee, but is slightly less in line with PRC principles.

The model with the system of tables and a modifying item, seemed most acceptable to the Plastic and Reconstructive Surgery Clinical Committee and the Taskforce, after consultation with members of the Taskforce, and is outlined below. The rules for the use of the tables follow the tables themselves, as does further rationale. As the dressings items and burns contracture items do not fit well into the same model, they are presented as revisions of existing items, in a standard list format.

Overview of burns excision and closure item revision

The revisions proposed will provide for a modern burns practice and will deliver clarity and appropriate use. Although the total benefit paid for burns surgery is low, it is important to have a Medicare Benefits Schedule that is fit for purpose. The Committee agreed that to allow ease of use, all the burns items (including the burns dressings items) should be allocated a new set of item numbers, which are sequential and uninterrupted.

In the proposed recommendations the existing 41 burns items will be replaced by 45 items. This option has the advantage of generating fewer new items than other options, but due to the presence of a modifier item, may necessitate claiming 4 items on many occasions. This proposal has been written so that more than one surgeon can claim the items at the same time. To allow this to occur appropriately it is proposed that aftercare be removed from the fees for the operative procedure for items referring to burns treatment on more than 10 per cent total body surface area. The alternative to this is to produce three versions of many of the items, one for a single specialist surgeon, one for a principal specialist surgeon in conjoint surgery and one for a conjoint specialist surgeon in conjoint surgery. The idea of having to treble the number of items was unwelcome and hence the proposal to remove the aftercare component.

6.1 Dressing of burns items

Table 29: Item introduction table for items 30003, 30006, 30010 and 30014

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30003	Localised burns, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$36.30	21,033	$661,728	25.8%
30006	Extensive burns, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$46.50	2,199	$87,152	15.8%
30010	Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$73.90	17	$652	-23.5%
30014	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$155.40	39	$3,647	16.7%

6.1.1 Recommendation 35

- Items 30003 and 30006: Change the descriptors and add an additional new item for outpatient burns dressings as follows:
    - Proposed descriptor for 30003:
        - BURNS, involving 1% or more but less than 3% of total body surface dressing of, without anaesthesia, each attendance at which the procedure is performed. Excludes skin reactions secondary to radiotherapy. Medical practitioner to be present. Includes redressing of any related donor site.
        - Nurse Practitioners should be provided access to item 30003.
    - Proposed descriptor for 30006:
        - BURNS, involving 3% or more but less than 10% of total body surface dressing of, without anaesthesia, each attendance at which the procedure is performed. Excludes skin reaction secondary to radiotherapy. Medical practitioner to be present. Includes redressing of any related donor site.

- Nurse Practitioners should be provided access to item 30003.

- Proposed new item 300XX:
    - BURNS, involving 10% or more of total body surface, dressing of, without anaesthesia, each attendance at which the procedure is performed. Excludes skin reactions secondary to radiotherapy. Medical practitioner to be present. Includes redressing of any related donor site.

The Committee recommends a schedule fee similar to that of dressing extensive burns under general anaesthesia (item 30014; $155.40)

6.1.2 Rationale for Recommendation 35

This recommendation focuses on ensuring the use of these items is for the intended population and protecting Medicare against unintended use.

- These items were originally developed for patients with burns as their primary clinical problem, being treated by specialists in the field of burns surgery. It appears from usage data that much of the use of these items has been by GPs and oncologists (approximately 62 per cent of usage of item 30003) perhaps to treat burns occurring as a side-effect of oncological treatment.
- The revised items are also worded with greater clarity so that there is no ambiguity about whether or not these are the appropriate items.
- The Committee considered high use of these items by oncologists to be indicative of misuse as the injuries which occasionally occur from extravasation of cytotoxic agents is defined as tissue necrosis, resulting in areas of dry or moist desquamation. These skin injuries are often treated by nurses and the Committee considered that claiming of burns items for these skin injuries was not appropriate. The Committee considered that routine medical management of patients undergoing radiation therapy is intrinsic to radiation oncology treatment items in Group T2, Subgroup 3 of the Schedule.
- Proposed new item: The Committee considered that there are infrequent cases where it is clinically appropriate to redress burns of 10 per cent or more total body surface area without anaesthesia and therefore recommends a new item to account for this indication. As this procedure involves significant time and expertise the Committee considered that it should not be remunerated or grouped the same as dressings for small burns and recommend remuneration

at the same rate as item 30014. This recommendation is in line with providing a robust and complete Schedule.

- It should be noted that item 30003 is the second highest used item in the Plastic and Reconstructive Surgery Clinical Committee scope of item numbers and that the rewording proposed is likely to represent cost saving to Medicare.
- The Plastic and Reconstructive Surgery Clinical Committee consider it appropriate that access to items 30003 and 30006 is provided to Nurse Practitioners.

6.1.3 Recommendation 36

- Items 30010 and 30014: Amend the descriptors and add two new items for burns dressings under anaesthesia.

  - Proposed descriptor for item 30010
    - BURNS, involving not more than 3% total body surface area burns dressing of, in an operating theatre under general anaesthesia or intravenous sedation. Medical practitioner to be present. Includes redressing of any related donor site (Anaes.)
  - Proposed descriptor for item 30014
    - BURNS, involving 3% or more but less than 20% total body surface area burns dressing of, in an operating theatre under general anaesthesia or intravenous sedation. Medical practitioner to be present. Includes redressing of any related donor site (Anaes.)
  - Proposed new item 300XX
    - BURNS involving 20% or more but less than 50% total body surface area or burns of less than 20% total body surface area involving 1% or more total body surface area within the hands or face dressing of, in an operating theatre under general anaesthesia or intravenous sedation. Medical practitioner to be present. Includes redressing of any related donor site (Anaes.)(Assist.)
  - The Committee recommends a schedule fee 50% greater than of item 30014 above, ($155.40 x 150% = $233.10) Proposed new item 300XX
    - BURNS involving 50% or more total body surface area (flame burns, scalds, contact burns or other thermal, chemical or electrical burns) dressing of, in an operating theatre under general anaesthesia or intravenous sedation.

Medical practitioner to be present. Includes redressing of any related donor site (Anaes.)(Assist)

- The Committee recommends a schedule fee 50% greater than of proposed new item 300XX above, ($233.10 x 150% = $349.65)

6.1.4 Rationale for recommendation 36

This recommendation focuses on improving clarity by introducing total body surface area concepts into these descriptors. This also enables distinction between different levels of work for different magnitude of burns.

- In addition, these descriptors reflect modernisation of practice as intravenous sedation with an anaesthetist is a common mode of operation, as well as general anaesthesia.
- The wording of the proposed item descriptors prevents a nurse alone performing the procedure, which will enable appropriate selection and claiming of these items.
- The committee does recommend an increase in remuneration for these items to reflect the time required to perform these procedures.
- It is expected that with the implementation of this recommendation, item usage for burns dressings under anaesthesia will remain the same as current levels, but total benefits paid will increase slightly in line with increase in remuneration levels for individual items. This is unlikely to have a major impact as total benefits paid for 2016/2017 for item 30014 was $3647.

6.2 Burns excision and closure items

The mainstay of closure of defects following burn excision has been autologous skin graft up until the last 15 - 20 years. However, the practice of burns surgery has changed significantly with the advance of technology, which has produced dermal analogues and bio-engineered skin substitutes. This has changed not only the nature of individual procedures, but also the pattern of treatment. In modern burns practice, patients will often have a complete burn excision and application of skin substitutes as the first stage of a two or three stage course of surgical procedures. The de-lamination of the skin substitute and delayed skin grafting often constitute these later procedures. The advent of skin substitutes and this type of treatment allows for complete burn excision and coverage at the first operation, where previously this was not possible in many large burns, due to lack of autologous skin graft donor sites. Early

complete burn excision and coverage has been shown to correlate with increased survival and reduced risk of wound infection.

6.3 Free grafting (split skin) to burns

Table 30: Item introduction table for items 30017, 30020, 45406, 45409, 45412, 45415, 45418, 45460-45462, 45464-45466, 45468, 45469, 45471, 45472, 45474, 45475, 45477, 45478, 45480, 45481 and 45483-45494

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
30017	Burns, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)	$326.05	156	$35,461	24.1%
30020	Burns, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)	$635.00	15	$7,058	20.1%
45406	Free grafting (split skin) to burns, including excision of burnt tissue - involving not more than 3% of total body surface (Anaes.) (Assist.)	$451.10	102	$32,804.75	13.6%
45409	Free grafting (split skin) to burns, including excision of burnt tissue - involving 3% or more but less than 6% of total body surface (Anaes.) (Assist.)	$601.65	20	$8,771.40	4.6%
45412	Free grafting (split skin) to burns, including excision of burnt tissue - involving 6% or more but less than 9% of total body surface (Anaes.) (Assist.)	$827.30	7	$4,185.55	-14.1%
45415	Free grafting (split skin) to burns, including excision of burnt tissue - involving 9% or more but less than 12% of total body surface (Anaes.) (Assist.)	$902.30	17	$10,828.00	23.2%
45418	Free grafting (split skin) to burns, including excision of burnt tissue - involving 12% or more but less than 15 per cent of total body surface (Anaes.) (Assist.)	$977.55	5	$3,666.00	0.0%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45460	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Anaes.) (Assist.)	$1,253.30	3	$2,820.00	-5.6%
45461	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$893.25	12	$6,989.45	5.9%
45462	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, co- surgeon (Assist.)	$674.05	1	$505.55	0.0%
45464	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Anaes.) (Assist.)	$1,913.10	2	$2,869.80	-12.9%
45465	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$1,363.00	6	$5,606.25	8.4%
45466	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$1,027.95	-	$0.00	-100.0%
45468	Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$1,832.65	2	$2,749.05	0.0%
45469	Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$1,382.70	-	$0.00	-

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45471	Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$2,303.65	1	$1,727.75	-
45472	Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$1,737.60	-	$0.00	-100.0%
45474	Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$2,773.30	-	$0.00	-
45475	Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$2,092.45	-	$0.00	-
45477	Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$3,243.00	-	$0.00	-
45478	Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$2,446.05	-	$0.00	-
45480	Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$3,712.60	-	$0.00	-
45481	Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$2,801.10	1	$2,100.85	0.0%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45483	Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$4,229.95	-	$0.00	-
45484	Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, co-surgeon (Assist.)	$3,191.50	-	$0.00	-
45485	Free grafting (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.)	$527.70	9	$2,275.90	-
45486	Free grafting (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.)	$451.10	11	$1,691.85	4.1%
45487	Free grafting (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.)	$406.05	6	$859.60	3.7%
45488	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.)	$451.10	2	$507.55	14.9%
45489	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.)	$676.80	1	$507.60	-
45490	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.)	$902.50	1	$676.90	-
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.)	$1,128.05	-	$0.00	-
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.)	$1,353.60	1	$1,015.20	0.0%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45493	Free grafting (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.)	$406.05	39	$4,667.80	13.2%
45494	Free grafting (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.)	$1,638.70	1	$1,228.90	-

6.3.1 Recommendation 37

- Delete all current burns excision and closure items and generate new items, sequentially numbered, in three tables (A, B and C) with one additional item and one modifier item outside of the tables.
- The proposed fees for these items exclude aftercare as the Committee recommends that both participating burns surgeons should be allowed to claim consultation or burns dressing items as appropriate during the aftercare period. This is appropriate to the modern pattern of burns surgery care and also prevents massive further expansion of the Schedule.
- The proposed Schedule fees for the new burns items are based on splitting the current fees 50-50 for excision and closure, as well as averaging out the current fees where the new total body surface area categories are across more than one of the current total body surface area categories. These fees are then halved 50-50 between Table A (excision) and Table B/Table C (closure) items.
- Due to the multiple operations rule the schedule fees of the new items have been increased to ensure the same fee is paid for the same procedure, which the Committee recommends splitting between excision and closure of burn.

Modifier Item (Burns involving hands, face or anterior neck)

Item	Descriptor	Schedule fee
45XXX(mod)	Where excision of burnt tissue or definitive burn wound closure involves greater than 1% of hands or face the derived fee is an additional 20% of the scheduled fee for that item.	+20%

Table A. Excision of Burnt Tissue Items (10 items)

Item	Descriptor	Schedule fee
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving not more than 3% of the total body surface (Anaes.)(Assist.)	$225.00
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 3% or more but less than 10% of the total body surface (Anaes.)(Assist.)	$357.25
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 10% or more but less than 20% of the total body surface, excluding aftercare (Anaes.)(Assist.)	$391.80
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 20% or more but less than 30% of total body surface, excluding aftercare (Anaes.)(Assist.)	$597.75
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 30% or more but less than 40% of total body surface, excluding aftercare (Anaes.)(Assist.)	$803.85
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 40% or more but less than 50% of total body surface, excluding aftercare (Anaes.)(Assist.)	$1,010.30
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 50% or more but less than 60% of total body surface, excluding aftercare (Anaes.)(Assist.)	$1,216.45
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 60% or more but less than 70% of total body surface, excluding aftercare (Anaes.)(Assist.)	$1,422.25
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 70% or more but less than 80% of total body surface, excluding aftercare (Anaes.)(Assist.)	$1628.42
45XXX	EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving 80% or more of total body surface, excluding aftercare (Anaes.)(Assist.)	$1,855.35

Excision items for whole of face (outside of table A)

- The proposed item descriptors is as follows:

- EXCISION OF BURNT TISSUE where wound closure is performed at the same procedure - involving whole of face (excluding ears). May be claimed with an item number in table A based on the % total body surface area outside of the specified sites, excluding aftercare.

The Committee recommends a schedule fee half that of the current item for excision and free grafting for whole of face (item 45494; $1,638.70 / 2 = $819.35)

Table B. Immediate Closure Items (for temporary or definitive closure) (15 items)

Item	Descriptor	Schedule fee
45XXX	EXCISED BURN WOUND CLOSURE or CLOSURE OF SKIN DEFECT SECONDARY TO BURNS CONTRACTURE RELEASE of not more than 3% of total body surface, where performed at the same procedure as primary burn wound excision or contracture release (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound) (Anaes.)(Assist.)	225.00
45XXX	EXCISED BURN WOUND CLOSURE or CLOSURE OF SKIN DEFECT SECONDARY TO BURNS CONTRACTURE RELEASE of 3% or more but less than 10% of total body surface, where performed at the same procedure as primary burn wound excision or contracture release (involving autologous or allogenic skin grafting, biological dressings or biosynthetic skin substitutes to temporize the excised wound) (Anaes.)(Assist.)	$357.25
45XXX	EXCISED BURN WOUND CLOSURE or CLOSURE OF SKIN DEFECT SECONDARY TO BURNS CONTRACTURE RELEASE of 10% or more but less than 20% of total body surface, where performed at the same procedure as primary burn wound excision or contracture release (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$391.80
45XXX	EXCISED BURN WOUND CLOSURE of 20% or more but less than 30% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$597.75
45XXX	EXCISED BURN WOUND CLOSURE of 30% or more but less than 40% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$803.85
45XXX	EXCISED BURN WOUND CLOSURE of 40% or more but less than 50% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$1,010.30

Item	Descriptor	Schedule fee
45XXX	EXCISED BURN WOUND CLOSURE of 50% or more but less than 60% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$1,216.45
45XXX	EXCISED BURN WOUND CLOSURE of 60% or more but less than 70% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$1,422.25
45XXX	EXCISED BURN WOUND CLOSURE of 70% or more but less than 80% of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$1628.42
45XXX	EXCISED BURN WOUND CLOSURE of 80% or more of total body surface, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$1,855.35
45XXX	EXCISED BURN WOUND CLOSURE of whole of face, where performed at the same procedure as primary burn wound excision (involving autologous or allogenic skin grafting, or biosynthetic skin substitutes to temporize the excised wound), excluding aftercare (Anaes.)(Assist.)	$819.35
45XXX	NON-EXCISIONAL DEBRIDEMENT OF SUPERFICIAL or MID-DERMAL PARTIAL THICKNESS BURNS of not more than 3% of total body surface AND APPLICATION OF SKIN SUBSTITUTE (skin allograft, biosynthetic epidermal replacements) (Anaes.)(Assist.)	$225
45XXX	NON-EXCISIONAL DEBRIDEMENT OF SUPERFICIAL or MID-DERMAL PARTIAL THICKNESS BURNS of 3% or more but less than 10% of total body surface AND APPLICATION OF SKIN SUBSTITUTE (skin allograft, biosynthetic epidermal replacements) (Anaes.)(Assist.)	$357.25
45XXX	NON-EXCISIONAL DEBRIDEMENT OF SUPERFICIAL or MID-DERMAL PARTIAL THICKNESS BURNS of 10% or more but less than 30% of total body surface AND APPLICATION OF SKIN SUBSTITUTE (skin allograft, biosynthetic epidermal replacements), excluding aftercare (Anaes.)(Assist.)	$494.80
45XXX	NON-EXCISIONAL DEBRIDEMENT OF SUPERFICIAL or MID-DERMAL PARTIAL THICKNESS BURNS of 30% or more of total body surface AND APPLICATION OF SKIN SUBSTITUTE (skin allograft, biosynthetic epidermal replacements), excluding aftercare (Anaes.)(Assist.)	$907.10

Table C. Delayed Definitive Closure Items (6 items)

Item	Descriptor	Schedule fee
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS OR SECONDARY TO RELEASE OF BURNS SCAR CONTRACTURE of not more than 3% of total body surface using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (Anaes.)(Assist.)	225.00
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS OR SECONDARY TO RELEASE OF BURNS SCAR CONTRACTURE of 3% or more but less than 10% of total body surface using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (Anaes.)(Assist.)	$357.25
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS OR SECONDARY TO RELEASE OF BURNS SCAR CONTRACTURE of 10% or more but less than 20% of total body surface using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings, excluding aftercare (Anaes.)(Assist.)	$391.80
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS of 20% or more but less than 30% of total body surface using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (Anaes.)(Assist.)	$597.75
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS of 30% or more of total body surface using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (Anaes.)(Assist.)	$1,322.80
45XXX	DEFINITIVE BURN WOUND CLOSURE OR CLOSURE OF SKIN DEFECT SECONDARY TO NECROTISING FASCIITIS of whole of face using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (Anaes.)(Assist.)	$819.35

Rules for Burns Excision and Closure Item Tables

- Where the modifer item (item XXXXX) is required, there is an exemption from the 3 item rule.
- Only one item can be claimed from Table A (Excision Items) for one provider in one operation.

- For any size of burn, each surgeon can work with another surgeon and each surgeon chooses the excision item from Table A based on the area that they, as an individual surgeon, have excised. Where two surgeons are claiming item numbers, the sum of items of each of the surgeons must match the total percentage surface area of burn for that patient.
- Items from Table A can be co-claimed with items from Table B (Immediate closure items) and with the modifier item, but not with items from Table C.
- Two items can be claimed from Table B, where indicated, but Table B numbers cannot be co-claimed with items from Table C.
- Items from Table C cannot be co-claimed with items from Tables A or B, but can be co-claimed with the modifier Item.

Clinical Scenario

A patient with 34 per cent total body surface area full-thickness burns and 3 per cent superficial burns is taken to theatre by two specialist burns surgeons. The burns involve both parts of the hands and parts of the face.

First operation under general anaesthetic

All the full-thickness burns are excised – 14 per cent by surgeon 1 and 20 per cent by surgeon 2. Surgeon 1 is responsible for the surgery on the hands and face and also debrides the superficial burns and dresses them with a biological dressing. Surgeons 1 and 2 both perform immediate closure of full-thickness burns using skin substitutes (17 per cent each).

Surgeon 1 would claim for excision of 14 per cent from Table A plus the modifier for the hands and face, and would claim for burn wound closure with a skin substitute of 17 per cent total body surface area (from Table B) and non-excisional debridement and application of biological dressing for 3 per cent from Table B.

Surgeon 2 would claim for excision of 20 per cent from Table A and would claim for burn wound closure with a skin substitute from Table B. Surgeon 1 manages the initial post-operative care.

Second operation under general anaesthetic

The skin substitutes have incorporated and the patient is returning to theatre for delamination of the skin substitutes and split skin grafting. There are insufficient donor sites

to graft all of the involved total body surface area and 20 per cent are planned for grafting in this operation. It is planned to leave the hands and face until the subsequent operation. Surgeon 1 does this procedure as a single surgeon.

Surgeon 1 would claim for definitive closure of 20 per cent total body surface area not involving hands and face. This would be from Table C and would not require the use of the modifier.

Surgeon 1 manages the early post-operative care but then hands over care to surgeon 2.

Third operation under general anaesthetic

The previous donor sites have healed and the patient is returning to theatre for delamination of the remaining skin substitutes and split skin grafting, including for the hands and face. Surgeon 1 is away and the procedure is carried out by Surgeon 2 and Surgeon 3. Surgeon 2 is more experienced and does the hands and face. Both surgeons do 10 per cent total body surface area each.

Surgeon 2 would claim for definitive closure of 10 per cent involving hands and face from Table C with the modifier item.

Surgeon 3 would claim for definitive closure of 10 per cent from Table C without claiming the modifier.

Surgeon 2 continues to manage the post-operative care.

Change of dressings under general anaesthetic

The patient requires a change of dressings under GA. This is performed by Surgeon 1 who claims for this from the dressings table.

Outpatient Visit 1

The patient attends Surgeon 1's rooms 2 weeks later for a further change of dressings. Surgeon 1 claims this from the dressings table.

Outpatient Visit 2

The patient healed 8 weeks post-burn and now attends Surgeon 1's rooms to discuss issues around scar contractures and long term functional impairments. Surgeon 1 claims a 105 for this visit.

6.3.2 Rationale for Recommendation 37

Implementation of Tables for Excision (Table A), Immediate Closure (Table B) and Definitive closure (Table C), allows for appropriate team working of multiple surgeons. Each surgeon can claim for the component of the surgery that they perform. This is in tune with modern burns surgery practice.

Implementation of the Tables also allows for the modern practice of utilizing skin substitutes which are an integral and established part of modern burns practice.

Implementation of the tables will result, in most cases, meeting the three item rule. The exceptions to this are where a patient has a whole face burn as well as burns in other sites or where a modifier is claimed for hand and face burns.

In order to be conservative about the number of new items generated, two strategies have been used:

- Firstly the tables and their rules have been designed so that each individual surgeon can claim their component of a procedure. If the system of having separate items for a single surgeon plus a principal specialist surgeon of a conjoint procedure and a conjoint specialist surgeon of a conjoint procedure the number of items generated would be almost trebled. For the proposed system to work, it must be permissible for two burns surgeons to claim the same items (e.g. in the circumstances of a 20 per cent burn where each surgeon excises and closes 10 per cent total body surface area). To facilitate this, the aftercare component can be separated out from the items. The only other option is to consider each operating surgeon as equal co-surgeons for the purposes of not only operative procedures but also post-operative "aftercare".
- Secondly, the bracketing of per cent total body surface area has been broadened. This will reduce the granularity of information it is possible to gather on burns patients and burns surgery activity, but it was decided that this was an appropriate compromise in order to keep the number of item numbers reasonable.

Necrotising fasciitis is an unusual condition, nearly always treated in a public hospital. Patients after debridement may have defects of 1 per cent total body surface area or, at the other end of the spectrum 20-30 per cent total body surface area. Until now there have not been satisfactory codes for grafting these skin defects. The ability to use same codes as the burns closure item numbers for this condition will mean that a further set of items will not need to be generated to provide for this previously poorly coded area. This will have a minimal impact on total benefits paid, as this condition is nearly always treated in a public hospital.

6.4 Burns contracture release and escharotomy

Table 31: Item introduction table for items 45519 and 45054

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45519	Extensive burn scars of skin (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)	$429.05	13	$2,875.00	-10.8%
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)	$246.10	2	$201.40	0.0%

6.4.1 Recommendation 38

- Item 45519: Amend item descriptor and generate three new items to account for extent of defect.
  - The proposed items descriptors are:
    - New item: BURNS CONTRACTURE, release of by excision or incision of scar, with the resultant defect being less than 1% of total body surface, including direct repair if performed (Anaes.)(Assist.).
    - Item 45519: BURNS CONTRACTURE, release of by excision or incision of scar, with the resultant defect being more than 1% but less than 3% of total body surface (Anaes.)(Assist.).
    - New item: BURNS CONTRACTURE, release of by excision or incision of scar, with the resultant defect being more than 3% but less than 10% of total body surface (Anaes.)(Assist.).

- New item: BURNS CONTRACTURE, release of by excision or incision of scar, with the resultant defect being more than 10% but less than 20% of total body surface (Anaes.)(Assist.).

- These items would be used alongside closure items in Tables B and C where the defect was not closed by other means (such as local flaps).
- Item 45054: No change; however, the Committee proposed increasing the schedule fee similar to that of item 30017 ($326.05).

6.4.2 Rationale for Recommendation 38

This recommendation is based on providing a robust Schedule consistent with modern surgical burns care.

- Item 45519: Burns contractures cause significant limitation in function, often occurring across joints or between face and neck. Release of such contractures often requires several hours of careful dissection to avoid damage to distorted underlying structures. The current Schedule does not adequately provide for differing magnitudes of contracture release.
- A burns scar contracture of less than 1 per cent total body surface area can still cause significant disability and should be catered for within the Schedule. The Committee regards the area of burns scar contracture procedures to be very low risk in terms of potential for misuse (total benefits paid in FY 2016/2017: $2875) and considered that implementation of this recommendation is unlikely to increase total activity.
- Item 45054: Escharotomy is a procedure that is life-saving and requires significant skill as the patient is often critically ill with significant blood loss. Current item 30017 describes a procedure of similar magnitude and is therefore an acceptable fee comparator.

7. Recommendations: Cranio-maxillofacial /Oral and Maxillofacial Surgery

Cranio-maxillofacial and Oral and Maxillofacial surgery has undergone major changes in the last 20 years due to changes in technology and fixation techniques. The majority of the changes in this section relate to modernisation of the Schedule to be consistent with standard practice and remove low value and redundant items.

Although this is a developing field of surgical practice this section of the Schedule has remained largely untouched and is currently out of date. The following recommendations are in line with updating terminology and practices to allow for modern best clinical practice, which will in turn provide greater clarity in the Schedule and enable appropriate selection and claiming of item numbers within this section of the Schedule.

7.1 Orbital cavity items

Table 32: Item introduction table for items 45590 and 45593

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45590	Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.)	$483.25	172	$44,810	-0.5%
45593	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	$567.65	29	$9,469	-9.6%

7.1.1 Recommendation 39

- Item 45590: Change descriptor to include use of bone or cartilage.
  - The proposed item descriptor is as follows:
    - Orbital cavity, reconstruction of wall or floor with bone or cartilage graft, with or without foreign implant (Anaes.) (Assist.)

- Item 45593: Change descriptor to include both orbital wall and floor and delete reference to prolapsed or entrapped orbital contents.
    - The proposed item descriptor is as follows:
        - Orbital cavity, reconstruction of wall and floor with bone or cartilage graft, or foreign implant (Anaes.) (Assist.)

The Committee recommends a schedule fee of 1.5 times the current fee for item 45593 to account for reconstruction of both wall and floor.

7.1.2 Rationale for Recommendation 39

- The Committee proposed changes to these item descriptors to clarify their indication as the purpose of the bone, cartilage or foreign implant is to reconstruct either the orbital wall or floor or both. Reduction of prolapsed or entrapped orbital contents is considered intrinsic to the procedure and therefore deemed unnecessary and should be removed from the item descriptor. The Committee considers that these changes will have no effect on usage or billing.

7.2 Maxilla and mandible resection and reconstruction

Table 33: Item introduction table for items 45596, 45597, 45599, 45602, 45605, 45608 and 45611

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45596	Maxilla, total resection of (Anaes.) (Assist.)	$900.45	11	$5,909	-8.3%
45597	Maxilla, total resection of both maxillae (Anaes.) (Assist.)	$1,205.40	1	$904	0.0%
45599	Mandible, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.)	$936.55	2	$1,008	-
45602	Mandible, including lower border, or maxilla, sub-total resection of (Anaes.) (Assist.)	$699.45	153	$52,837	15.3%
45605	Mandible or maxilla, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	$587.60	284	$83,882	19.0%
45608	Mandible, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)	$827.30	21	$4,484	16.0%
45611	Mandible, condylectomy (Anaes.) (Assist.)	$473.75	3	$533	-12.9%

7.2.1 Recommendation 40

- Item 45596: Change the descriptor to update terminology.
  - The proposed item descriptor is as follows:
    - Hemimaxillectomy (Anaes.)(Assist)
- Item 45597: Change the descriptor to update terminology.
  - The proposed item descriptor is as follows:
    - Total maxillectomy (bilateral) (Anaes.) (Assist.)
- Item 45599: Change the descriptor to simplify and improve the clarity of the descriptor.
  - The proposed item descriptor is as follows:
    - Mandible, total resection of (Anaes.) (Assist.)

- Items 45602 and 45605: No change.
- Item 45608: Change the item descriptor to better describe the service.
  - The proposed item descriptor is as follows:
- Mandible, segmental mandibular or maxilla reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)Item 45611: Minor change to the descriptor.
  - The proposed item descriptor is as follows:
    - Mandible, condylectomy of (Anaes.) (Assist.)
- New Item: Create a new item for reconstruction of a maxilla, mandible or skull base using a free flap (bony reshaping).
  - The proposed item descriptor is as follows:
    - MANDIBLE, MAXILLA OR SKULL BASE, reconstruction of, using bony free flap, all osteotomies, shaping, inset and fixation by any means, including all necessary three dimensional planning, when in conjunction with a bone-containing free flap (i.e. in association with items new items 455M3 – 455M7).

7.2.2 Rationale for Recommendation 40

- These recommendations are in line with modernising the terminology within the Schedule. These are wording changes only and do not represent changes to the nature of the procedures being performed and are therefore unlikely to have any impact on usage or billing.
- Items 45596 and 45597: In the past, the term 'maxilla' referred to one of the two identical bones that form the upper jaw with the maxillae meeting in the midline of the face. Today the maxilla is considered a double structure or one bone (ie. the entire upper jaw). A hemimaxillectomy refers to the surgical removal of one side of the upper jaw while a total maxillectomy refers to the removal of all of the maxilla (ie. both sides). For item 45597 the Committee considered it necessary to include the term "bilateral" in brackets to "grandfather" previous use of this terminology.
- Item 45599: The Committee recommends updating the item descriptor to increase clarity around appropriate circumstances for claiming. Total resection of the mandible by definition includes the condyles and the Committee agreed that inclusion of condylecotmies in the descriptor adds confusion and gives an

impression that a total resection may include a subtotal resection, which is not what the item is intended for.

- Items 45602 and 45605: The Committee considered these items consistent with current clinical practice and recommends no change
- Item 45608: The Committee considered that the current wording of descriptor does not reflect modern practice as this procedure involves using bone graft for a variety of missing segments and not necessarily exactly half a mandible. The recommendation is therefore based on modifying and clarifying indication for this item.
- Item 45611: The Committee recommends a very minor change to item descriptor.
- New item: The Committee considered the creation of a new item is consistent with modern clinical practice and modernisation of the schedule.

7.3 Correction of choanal atresia

Table 34: Item introduction table for items 45645 and 45646

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45645	Choanal atresia, repair of by puncture and dilatation (Anaes.)	$223.60	7	$1,048	11.8%
45646	Choanal atresia, correction by open operation with bone removal (Anaes.) (Assist.)	$900.45	7	$4,390	-4.9%

7.3.1 Recommendation 41

- Items 45645 and 45646: No change.

7.3.2 Rationale for Recommendation 41

- Choanal atresia is a rare condition, however the Committee agreed that these items remain relevant for certain patients and that the current descriptors accurately describe clinically indicated procedures.

7.4 Facial reconstructive contouring

Table 35: Item introduction table for item 45647

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45647	Face, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.)	$1,279.45	195	$121,408.30	11.7%

7.4.1 Recommendation 42

- Items 45647: Change the item descriptor to add a requirement for pathology (congenital absence of tissue or trauma). Restrict use of this item when item 45897 (alveolar bone grafting) can be used. The Committee also suggests moving this item number closer in the schedule to item 45897 (or the other way around) to enable appropriate claiming of items and improve the logic of the Schedule.
    - The proposed item descriptor is as follows:
        - Face, contour restoration of 1 region, for the correction of deformity using autogenous bone or cartilage where the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than from previous cosmetic surgery), or a diagnosed pathological process (not being a service to which item 45644 or 45897 (alveolar bone grafting) applies) (Anaes.) (Assist.)

7.4.2 Rationale for Recommendation 42

The Committee felt that some clinicians may currently be using this item for alveolar bone grafting, which is a different procedure with a different level of complexity and which has its own item number. The addition of criteria around the presence of pathology in the item descriptor is in line with clarifying the Schedule to safeguard this item from cosmetic misuse and enable clinicians to appropriately claim item numbers.

7.5 Oro-nasal fistula and velopharyngeal insufficiency

Table 36: Item introduction table for items 45714 and 45716

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45714	Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.)	$781.95	38	$15,391.70	-2.9%
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$781.95	68	$25,502.65	20.3%

7.5.1 Recommendation 43

- Item 45714: Change the descriptor to update terminology.
  - The proposed item descriptor is as follows:
    - Oro-nasal fistula, including a local flap for closure (Anaes.) (Assist.)
- Item 45716: No change.

7.5.2 Rationale for Recommendation 43

This recommendation is in line with simplifying and modernising the Schedule.

- Item 45714: The Committee agreed that the term 'plastic closure' is an archaic term which is inconsistent with modern terminology and recommends updating the item descriptor as above.
- Item 45716: The Committee considered this item clinically relevant and appropriate and recommends no change.

7.6 Mandible or maxilla osteotomy items

Table 37: Item introduction table for items 45720, 45723, 45726, 45729, 45731, 45732, 45735, 45738, 45741, 45744, 45747 and 45752-45754.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45720	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.)	$966.80	194	$138,304.78	-2.5%
45723	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,090.35	31	$16,941.55	-12.1%
45726	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,232.05	115	$105,499.95	19.6%
45729	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,383.65	229	$235,804.55	16.0%
45731	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,402.70	73	$74,077.60	11.2%
45732	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such	$1,579.20	139	$155,934.15	17.1%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)				
45735	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,611.05	11	$13,291.25	29.7%
45738	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,812.40	98	$133,211.10	22.2%
45741	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,772.30	-	$0.00	-
45744	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any	$1,992.70	60	$89,330.55	25.9%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)				
45747	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$1,933.55	-	$0.00	-100.0%
45752	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$2,165.75	75	$119,200.65	15.8%
45753	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2,178.60	-	$0.00	-
45754	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$2,611.60	1	$1,958.70	-12.9%

7.6.1 Recommendation 44

- Items 45720, 45723, 45726, 45729, 45731, 45732, 45735, 45738, 45741, 45744, 45747 and 45752: Restructure these items into nine new items, six of which account for principal, conjoint and single surgeons:
    - The proposed item descriptors for advancement, retrusion or alteration of tilt by osteotomy in standard planes are as follows:
        - MANDIBLE OR MAXILLA, procedure for advancement, retrusion or alteration of tilt of, by osteotomy in standard planes (e.g. sagittal split of mandible / horizontal osteotomy of maxilla) including fixation by any means including application of distractors where used. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)

The Committee recommends a schedule fee similar to that of item 45729; $1383.65.

- MANDIBLE AND MAXILLA, (bimaxillary) procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes (e.g. sagittal split of mandible / horizontal osteotomy of maxilla) including fixation by any means including application of distractors where used - conjoint surgery, principal specialist surgeon. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist).
- MANDIBLE AND MAXILLA, (bimaxillary) procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes (e.g. sagittal split of mandible / horizontal osteotomy of maxilla) including fixation by any means including application of distractors where used - conjoint surgery, conjoint specialist surgeon. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist).
- MANDIBLE AND MAXILLA, (bimaxillary) procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes (e.g. sagittal split of mandible / horizontal osteotomy of maxilla) including fixation by any means including application of distractors where used - single surgeon. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist).

The Committee recommends a schedule fee similar to that of item 45738; $1812.40.

- The proposed combined item descriptors for procedures involving arch reshaping, advancement, retrusion or tilting by complex segmental osteotomies are as follows:

  - MAXILLA, procedure for reshaping arch of, by complex segmental osteotomies, including fixation by any means including application of distractors where used. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)

The Committee recommends a schedule fee similar to that of item 45732; $1579.20.

  - MANDIBLE, procedure for reshaping arch of, by complex segmental osteotomies, including genioplasty, when performed, and including fixation by any means including application of distractors where used. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)

The Committee recommends a schedule fee similar to that of item 45732; $1579.20.

  - MANDIBLE AND MAXILLA, (bimaxillary) procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, plus or minus standard osteotomies and including genioplasty, when performed, and including fixation by any means including application of distractors where used - conjoint surgery, principal specialist surgeon (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)
  - MANDIBLE AND MAXILLA, (bimaxillary) procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, plus or minus standard osteotomies and including genioplasty, when performed, and including fixation by any means including application of distractors where used - conjoint surgery, conjoint specialist surgeon. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)
  - MANDIBLE AND MAXILLA, (bimaxillary) procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, plus or minus standard osteotomies and including genioplasty, when performed, and including fixation by any means including application of distractors where used - single surgeon. (Restricted to one service per patient per occasion of service)(Anaes.)(Assist)

The Committee recommends a schedule fee similar to that of item 45752; $2165.75.

- Items 45753 and 45754: Consolidate these items into three new items to account for principal, conjoint and single surgeons
    - The proposed item descriptor for is as follows:
        - Midfacial osteotomies, Le Fort II or Le Fort III - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.)
        - Midfacial osteotomies, Le Fort II or Le Fort III - conjoint surgery, conjoint specialist surgeon (Anaes.) (Assist.)
        - Midfacial osteotomies, Le Fort II or Le Fort III - single surgeon (Anaes.) (Assist.)

7.6.2 Rationale for Recommendation 44

This recommendation improves clarity, simplifies and modernises the Schedule. The proposed descriptors are in line with modern surgical practice (always using fixation with an osteotomy), the concept of a complete medical service and modern terminology. The Committee does not expect these changes to impact usage, activity or billing.

- The Committee considers that the current item descriptors are overly complex and include options with or without fixation. In current clinical practice it is not appropriate to perform osteotomies without fixation. Addition of 'including fixation by any means' in the item descriptors is to clarify inclusion of fixation, as fixation should always be used in current clinical practice osteotomies. Bony distractors are an established part of modern practice and so inclusion of the reference to distractors reflects modernisation of the schedule.
- The use of the term 'bimaxillary' is used to indicate both jaws (ie. upper and lower maxilla) to improve clarity. Retaining the "maxilla or mandible" provision could lead to inappropriate use and the proposed items will reduce this risk.
- In the current Schedule there is no distinction between simple osteotomies and the more complex osteotomies required to break up and remodel the maxilla.
- Segmental osteotomies of the maxilla are complex and are usually of a higher level of complexity than multiple mandibular osteotomies.

The Committee discussed osteotomies in the context of rural or remote locations and agreed that there should be incentive for conjoint surgeons in these procedures; however, this is not always possible. The Committee suggested creating item numbers to encourage conjoint surgery in the best interest of the patient, as well as retaining item numbers for the situation when a single surgeon is providing the procedure.

7.7 Genioplasty

Table 38: Item introduction table for items 45761

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$748.65	87	$36,735.95	6.0%

7.7.1 Recommendation 45

- Items 45761: Change the item descriptor to include the requirement of pathology (congenital absence of tissue or trauma) and the requirement for photographic evidence to be captured before treatment.
    - The proposed item descriptor is as follows:
        - Genioplasty, where the deformity is secondary to congenital absence of tissue or has arisen from trauma, (other than from previous cosmetic surgery), or a diagnosed pathological process or is required for maintaining lip competency. Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.) (Assist.)

7.7.2 Rationale for Recommendation 45

The rationale for this recommendation is the simplification of the Schedule and safeguarding Medicare against cosmetic misuse.

- Transposition of nerves and vessels and use of bone grafts are intrinsic to the procedure and do not need to be specified in descriptor.
- The Committee recommends including a requirement for pathology to be present and photographic evidence to be captured prior to treatment to safeguard this item against cosmetic misuse.

7.8 Correction of hypertelorism

Table 39: Item introduction table for items 45767 and 45770

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45767	Hypertelorism, correction of, intracranial (Anaes.) (Assist.)	$2,511.65	-	$0.00	-
45770	Hypertelorism, correction of, subcranial (Anaes.) (Assist.)	$1,923.90	-	$0.00	-

7.8.1 Recommendation 46

- Items 45767: Change the descriptor to clarify intracranial approach.
    - The proposed item descriptor is as follows:
        - Hypertelorism, correction of, using intracranial approach (Anaes.) (Assist.)
- Item 45770: Delete.

7.8.2 Rationale for Recommendation 46

These recommendations are in line with updating the Schedule to better reflect modern surgical best clinical practice.

- Item 45767: The Committee recommends changes to the wording of the descriptor to better reflect the complex nature of the procedure.
- Item 45770: The Committee considered this procedure no longer consistent with modern clinical best practice as correction of hypertelorism by subcranial approach is no longer recommended or performed.

7.9 Surgery for orbital malformations

Table 40: Item introduction table for items 45773, 45776 and 45779

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45773	Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Anaes.) (Assist.)	$1,753.40	-	$0.00	-
45776	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.)	$1,753.40	2	$2,630.15	-
45779	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	$1,289.15	-	$0.00	-

7.9.1 Recommendation 47

- Items 45773: Change the item descriptor to include syndromic orbital dystopia, specify bilateral reconstruction and allow for use of bone grafts from a distant site.
    - The proposed item descriptor is as follows:
        - Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial / periorbital reconstruction, with bone grafts from a distant site (Anaes.) (Assist.)
- Items 45776 and 45779: No change.

7.9.2 Rationale for Recommendation 47

- Item 45773: The Committee recommends replacing ‘rib and iliac bone grafts’ with ‘bone grafts from a distant site’ as bone grafts are sometimes obtained from calvarium or other sites. This change in wording allows for appropriate flexibility in the bone graft donor site.

The Committee also suggested changing the descriptor to include 'syndromic orbital dystopia, such as Treacher Collins' because although this is an eponymous syndrome, the Committee felt that on this occasion it should be retained, due to broad and established usage of this term and the specificity of this particular syndrome and its treatment requirements.

- Items 45776 and 45779: The Committee considered these items consistent with modern clinical practice and requiring no change

7.10 Surgery for congenital craniofacial malformations

Table 41: Item introduction table for items 45782, 45785, 45788, 45791 and 45853

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45782	Frontoorbital advancement, unilateral (Anaes.) (Assist.)	$985.70	2	$1,108.95	-26.0%
45785	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral fronto-orbital advancement) (Anaes.) (Assist.)	$1,668.10	32	$39,031.50	-2.9%
45788	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (Anaes.) (Assist.)	$1,649.10	2	$2,075.35	0.0%
45791	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	$890.85	2	$804.90	-
45853	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	$890.85	1	$668.15	-

7.10.1 Recommendation 48

- Item 45782: Change the item descriptor to reflect current clinical practice.
    - The proposed item descriptor is as follows:
        - Frontoorbital advancement (Anaes.)(Assist.)
- Item 45785: Change the item descriptor to update the terminology and reflect current clinical practice.
    - The proposed item descriptor is as follows:
        - Cranial vault reconstruction for single suture synostosis (Anaes.)(Assist.)

- Item 45788: Change the item descriptor to remove eponymous terminology and more accurately describe the procedure.
    - The proposed item descriptor is as follows:
        - Glenoid fossa, construction of, from bone and cartilage graft, and creation of condyle and ascending ramus of mandible, in hemifacial microsomia, not including harvesting of graft material (Anaes.) (Assist.)
- Item 45791: Change the item descriptor to update terminology.
    - The proposed item descriptor is as follows:
        - Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material. (Anaes.) (Assist.)
- Item 45853: Delete

7.10.2 Rationale for Recommendation 48

The recommendations above are based on improving clarity and updating Schedule to reflect current clinical practice. The proposals are minor word changes only with no implications for usage or billings.

- Item 45782: Unilateral advancement is not performed in current surgical practice so the Committee recommends to remove the term 'unilateral' from descriptor
- Item 45785: Replace ‘oxycephaly, brachycephaly, turricephaly or similar condition’ with ‘single suture synostosis’ because the current terminology it is not scientifically based and describes the shape of the head, whereas ‘suture synostosis’ describes the pathology. This recommendation is to be consistent with current clinical practice and modern terminology
- Item 45788: This is a very complex and rare procedure which is occasionally indicated. The Committee felt it is better to use scientific descriptors than an eponomyous term.
- Item 45791: The Committee recommends replacing ‘hemifacial microsomia’ with ‘craniofacial microsomia’. This is a simpler version of the procedure described by item 45788 as it requires construction of the jaw but not the socket.

- Item 45853: This item is a duplication of item 45791

7.11 Osseo-integration procedures

Table 42: Item introduction table for items 45794, 45797, 45845 and 45847

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45794	Osseo-integration procedure - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)	$503.85	34	$7,102.75	37.2%
45797	Osseo-integration procedure, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)	$186.50	39	$3,179.55	41.0%
45845	Osseo-integration procedure - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$503.85	70	$11,616.65	10.8%
45847	Osseo-integration procedure - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$186.50	23	$1,402.65	0.9%

7.11.1 Recommendation 49

- Items 45794: Change the item descriptor to reflect current clinical practice and include description of the pathology (congenital absence of tissue, tumour or trauma). Remove 'not for implantable bone conduction hearing system device' from proposed descriptor.
    - The proposed item descriptor is as follows:
        - Osseo-integration procedure, first stage: implantation of fixture, following congenital absence, tumour or following trauma (other

than trauma resulting from previous elective cosmetic surgery) (Anaes.)

- Item 45797: Change the item descriptor to reflect current clinical practice and include description of the pathology (congenital absence of tissue, tumour or trauma). Remove 'not for implantable bone conduction hearing system device' from proposed descriptor.
    - The proposed item descriptor is as follows:
        - Osseo-integration procedure, second stage: fixation of trancutaneous abutment, following congenital absence, tumour or following trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.)
- Item 45845: Change the item descriptor to allow for treatment due to trauma or congenital absence of maxilla or mandible.
    - The proposed item descriptor is as follows:
        - Osseo-integration procedure - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for a benign or a malignant tumour or following segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth). Fixture must be placed at site of the missing segment following appropriate reconstructive procedures. (Anaes.)
- Item 45847: Change the item descriptor to allow for treatment due to trauma or congenital absence of maxilla or mandible.
    - The proposed item descriptor is as follows:
        - Osseo-integration procedure - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for a benign or a malignant tumour or following segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth). Fixture must be placed at site of the missing segment following appropriate reconstructive procedures. (Anaes.)

7.11.2 Rationale for Recommendation 49

These recommendations reflect a need to improve and clarify the language for these item descriptors.

- Items 45845 and 45847: The main change proposed is that indications for surgery can include trauma or congenital absence of structures. Currently there is no provision for patients who have had a significant injury such as a gunshot wound to the face or for those with rare craniofacial disorders where there are congenital absences of the structures supporting the teeth. The proposed change could therefore result in a minor increase of usage and billing. The Committee noted that the recommended changes for items 45845 and 45847 will broaden the population who can be treated with this item; however, it will make these items available more equitably among different patient groups requiring this type of treatment.
- The Committee was careful to include a restriction to limit the use of these items to the area of the defect so that it cannot be used for cosmetic purposes elsewhere. Additionally, patients must pay for any crowns or bridge work themselves so this may limit the use of this item. The phrase 'multiple adjacent teeth' was included to prevent the use of this item for the loss of only one tooth.
- Item 45794: There was debate about whether osseo-integration was the correct term to use for this item, but there was a fear that simple screws and other fixation devices may be inappropriately labelled as "intraosseous fixation devices" if the name was changed.
- Items 45794 and 45797: The Committee recommends removing ‘not for implantable bone conduction hearing system device’ from proposed descriptors because there are other items available for implantation of implantable hearing systems and it is unnecessary to expand on what the item is not to be used for. In addition, magnetic bone conduction hearing implants have been designed to attract the sound processor to the implant, sending sound to the inner ear without anything breaking the skin.

7.12 Jaw Tumours and Cysts

Table 43: Item introduction table for items 45799, 45801, 45803, 45805, 45807, 45809, 45811 and 45813

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45799	Aspiration biopsy of 1 or more jaw cysts as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.)	$29.45	5	$125.25	0.0%
45801	Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.)	$126.90	2,083	$207,685.85	9.9%
45803	Tumours, cysts, ulcers or scars, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)	$326.05	104	$25,416.25	7.9%
45805	Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	$172.50	77	$10,310.85	1.4%
45807	Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by	$246.50	1,418	$215,248.65	22.8%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
	positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this subgroup applies, involving muscle, bone, or other deep tissue (Anaes.)				
45809	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this subgroup applies (Anaes.) (Assist.)	$371.50	910	$237,649.25	19.3%
45811	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)	$502.25	325	$108,276.30	13.4%
45813	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)	$587.60	53	$16,797.80	8.0%

7.12.1 Recommendation 50

- Item 45799: Delete.
- Item 45801, 45803 & 45805: Consolidate into a new item and clarify use in the oral cavity.
    - The proposed item descriptor is as follows:
        - Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation),in the oral cavity, removal from

mucosa or submucosal tissues, where the removal is by surgical excision and suture (Anaes.)

The Committee recommends a schedule fee calculated on the average of these items ($208.48).

- Items 45807, 45809, 45811, 45813: No change.

7.12.2 Rationale for Recommendation 50

- Item 45799: The Committee recommends deletion of this number as aspiration as an independent procedure is not used in modern clinical practice.
- Items 45801, 45803 and 45805: The Committee suggested consolidating these items as they felt there was significant overlap with the Skin Services items and because they are unnecessarily complex. The Committee felt that it was unnecessary to include details of size or number of lesions in the item descriptors and changes were based on simplifying the Schedule. Narrowing use of this item to the oral cavity was an attempt to ensure appropriate use of item and minimise duplication.
- Items 45807 and 45809: The Committee discussed removing the reference to the distance away from a tooth; however, decided to leave this in the descriptor as in the past some clinicians have misused this item number during a procedure to remove a tooth, which does not reflect the complexity of the intended use.
- Items 45811 and 45813: The Committee considered these items to be consistent with modern surgical care and therefore recommends no change

7.13 Surgery for osteomyelitis

Table 44: Item introduction table for items 45815, 45817 and 45819

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45815	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.)	$356.35	470	$118,219.60	40.8%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45817	Operation on skull for osteomyelitis (Anaes.) (Assist.)	$464.50	6	$1,306.50	-9.7%
45819	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 45817 (Anaes.) (Assist.)	$587.55	4	$1,366.40	-7.8%

7.13.1 Recommendation 51

- Item 45815: Change item descriptor to include requirement for radiological and laboratory evidence of osteomyelitis. Furthermore, expand the item to reflect management of radiation or medication induced osteonecrosis. The proposed item descriptor is as follows:
    - Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis with radiological and laboratory evidence of osteomyelitis OR operation on mandible or maxilla for necrosis of the jaw from any cause including medication or radiation induced that requires debridement of the alveolar bone or beyond. (Anaes.) (Assist.)
- Item 45817 and 45819: Delete.

7.13.2 Rationale for Recommendation 51

This recommendation is designed to modernise the Schedule to reflect current surgical practice.

- Item 45815: The Committee discussed including in the item descriptor 'not within 6 months of elective dental extraction'; however, decided not to include this restriction as osteomyelitis can occur as a result of a postoperative complication. The inclusion of the restriction (other than alveolar margins) was to prevent use of this item for dental extractions as they contain sockets of the teeth. The addition of requiring radiological and laboratory evidence of osteomyelitis is to clarify indication for this item in treatment of true osteomyelitis. Medication induced osteonecrosis of the jaw is a condition that has emerged since the development of the MBS schedule. It often requires treatment with debridement of necrotic bone which can be isolated to the alveolus and be quite extensive. There is no current MBS item to reflect

management of this condition and it is therefore recommended to be included within this item.

- Item 45817: The Committee noted infrequent claiming of this item and discussed whether it should be retained. The Committee concluded that true osteomyelitis of the skull is best treated by neurosurgeons who would use an item within the neurosurgery Schedule (39906: Osteomyelitis of skull or removal of infected bone flap, craniectomy for; $797.10). Item 45817 is possibly being used for less severe and superficial bone infections rather than true osteomyelitis and this kind of minimal unicortical debridement is instead covered by wound debridement items. Since this item is a duplication of the Schedule and is inconsistent with modern practice the Committee recommends deletion to prevent inappropriate care.
- Item 45819: The Committee felt this item was unnecessary as it is inconsistent with modern surgical practice and a duplication of other items in the Schedule.

7.14 Insertion of bone growth stimulator

Table 45: Item introduction table for item 45821

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45821	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.) (Assist.)	$380.80	285	$48,488.05	23.8%

7.14.1 Recommendation 52

- Items 45821: Delete.

7.14.2 Rationale for Recommendation 52

The recommendation to delete this item is based on reducing misuse and duplication in the Schedule.

- The indication for this item is unclear and the Committee agreed that it likely refers to insertion of an alloplast bone substitute (such as Bio-Oss), which is clearly covered by the item for alveolar ridge augmentation (45841: ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral; $473.65). The Committee considered item 45821 to be of low value and open to misuse

as shown by high co-claiming with alveolar ridge augmentation (approximately 70 per cent). The Committee also considered that co-claiming of this procedure with a removal of cyst, ulcer or scar as not well evidenced or a clinically valuable procedure. Item 45821 therefore has no clinical relevance and should be deleted from the Schedule.

7.15 Preprosthetic and reconstructive surgery

Table 46: Item introduction table for items 45825, 45827, 45829, 45837, 45839, 45841, 45843 and 45849

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45825	Mandibular or palatal exostosis, excision of (Anaes.) (Assist.)	$338.35	617	$138,441.90	14.7%
45827	Mylohyoid ridge, reduction of (Anaes.) (Assist.)	$323.40	43	$6,467.85	11.5%
45829	Maxillary tuberosity, reduction of (Anaes.)	$246.70	191	$27,319.30	33.5%
45837	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)	$586.50	101	$35,263.40	10.6%
45839	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.)	$586.50	5	$1,529.30	-9.0%
45841	Alveolar ridge augmentation with bone or alloplast or both - unilateral (Anaes.) (Assist.)	$473.65	2,720	$913,927.00	24.0%
45843	Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	$290.50	2	$301.45	0.0%
45849	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)	$580.90	456	$190,161.00	12.3%

7.15.1 Recommendation 53

- Items 45825, 45827, 45829, 45837 and 45841: No change.
- Item 45839: Consolidate into item 45837.
- Item 45843: Delete.
- Item 45849: Change the item descriptor to include use of allograft.
    - The proposed item descriptor is as follows:
        - Maxillary sinus, allograft, bone graft or both to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)

7.15.2 Rationale for Recommendation 53

- Items 45825, 45827, 45829, 45837 & 45841: The Committee considered these items consistent with current clinical practice and requiring no change.
- Item 45839: The Obwegeser technique is a form of vestibuloplasty, therefore this item is superfluous and the Committee recommends consolidation into item 45837.
- Item 45843: The Committee considered this item redundant as it was previously used for insertion of an inflatable tissue expansion device for alveolar ridge augmentation, which is considered to be a procedure no longer consistent with modern practice.
- Item 45849: The Committee recommends adding 'allograft' to the descriptor as this procedure is not pure bone augmentation to the sinus floor.

7.16 Papillary hyperplasia of the palate

Table 47: Item introduction table for items 45831, 45833 and 45835

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45831	Papillary hyperplasia of the palate, removal of - less than 5 lesions (Anaes.) (Assist.)	$323.40	19	$4,096.10	-3.7%
45833	Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Anaes.) (Assist.)	$406.05	2	$518.85	-16.7%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45835	Papillary hyperplasia of the palate, removal of - more than 20 lesions (Anaes.) (Assist.)	$503.85	-	$0.00	-

7.16.1 Recommendation 54

- Items 45831, 45833 and 45835: Consolidate into one item.
    - The proposed item descriptor is as follows:
        - Papillary hyperplasia of the palate, surgical reduction of, cannot be claimed more than once per occasion of service (Anaes.) (Assist.)

The Committee recommends a schedule fee similar to that of item 45831 ($323.40).

7.16.2 Rationale for Recommendation 54

This recommendation is based on simplifying and modernising the Schedule to be consistent with clinical practice.

These items were divided up by number of lesions, however, the Committee considered papillary hyperplasia of the palate to be a single, continuous, general condition rather than multiple distinct lesions; therefore, consolidation of these items into one item is appropriate as it is simpler and more appropriate to have a single item for this condition. Papillary hyperplasia of the palate is the technical name for small, tightly packed papillary (wart-like protuberances) growths of normal tissue cells that develop in the area of the mouth where dentures are worn constantly.

7.17 Temporomandibular joint procedures

Table 48: Item introduction table for items 45755, 45758, 45851, 45855, 45857, 45859, 45861, 45863, 45865, 45867, 45869, 45871, 45873, 45875, 45877 and 45879

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45755	Temporomandibular partial or total meniscectomy (Anaes.) (Assist.)	$367.75	1	$191.60	0.0%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45758	Temporo-mandibular joint, arthroplasty (Anaes.) (Assist.)	$658.05	2	$630.00	14.9%
45851	Temporomandibular joint, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this subgroup applies (Anaes.)	$142.95	7	$376.15	-8.6%
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)	$408.70	8	$2,708.75	51.6%
45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)	$653.80	20	$9,890.25	46.1%
45859	Temporomandibular joint, arthrotomy of, not being a service to which another item in this subgroup applies (Anaes.) (Assist.)	$329.60	-	$0.00	-100.0%
45861	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	$872.30	4	$654.20	0.0%
45863	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	$967.00	4	$2,507.05	-
45865	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	$290.50	120	$23,392.55	16.1%
45867	Temporomandibular joint, synovectomy of, not being a service to which another item in this subgroup applies (Anaes.) (Assist.)	$312.30	-	$0.00	-

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45869	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)	$1,188.20	4	$3,113.15	14.9%
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	$1,338.45	10	$9,849.65	27.2%
45873	Temporomandibular joint, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)	$1,504.05	6	$3,022.50	3.7%
45875	Temporomandibular joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$470.70	6	$1,331.85	14.9%
45877	Temporomandibular joint, arthrodesis of, with synovectomy if performed, not being a service to which another item in this subgroup applies (Anaes.) (Assist.)	$470.70	1	$353.05	0.0%
45879	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	$312.30	3	$1,409.65	8.4%

7.17.1 Recommendation 55

- Items 45755, 45758, 45859, 45861, 45863, 45867, 45869, 45875, 45877 and 45879: Delete
- Item 45851: Change item descriptor to clarify use as an independent procedure not associated with a service to which any other item applies.
    - The proposed item descriptor is as follows:

- Temporomandibular joint, manipulation of, as an independent procedure performed in the operating theatre of a hospital, not being a service associated with a service to which any other item in this Group applies (Anaes.)

- Item 45855: The Committee recommends reducing the schedule fee to be in line with arthrocentesis of the temporomandibular joint (item 45865:$290.50).
- Item 45857: Change the item descriptor to clarify indication.
    - The proposed item descriptor is as follows:
        - Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy, including repositioning of meniscus where indicated - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic or open procedure of the temporomandibular joint (Anaes.) (Assist.)
- Items 45865, 45871 and 45873: No change.
- Create a new item to describe total temporomandibular joint replacement.
    - The proposed item descriptor as follows:
        - Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (Anaes.) (Assist.)

The Committee recommends a schedule fee similar to that of either hip (49318; $1,317.80) or knee replacement (49518; $1,317.80).

7.17.2 Rationale for Recommendation 55

This recommendation reflects the simplification of the Schedule and removal of redundant items. Those medically qualified oromaxillofacial surgeons who can access items in section 3 may access any item in section 3, therefore the items do not need to be duplicated in the CMF and OMS subsections of section 3. Avoiding duplication is therefore the underlying reason for the recommendation. This recommendation is also based on protecting Medicare against misuse and removing funding of low value procedures.

- Item 45851: The Committee considered this item open to misuse and recommends changing the item descriptor to enable clinicians to appropriately use this item number.
- Item 45855: Arthroscopy of the temporomandibular joint for diagnostic purposes alone is often a low-value procedure with unproven benefits, however the Committee considered that removal of this item number would

disadvantage the community. An arthroscopic procedure can be indicated and diagnostically valuable for clarity in patient management and treatment with lysis and lavage including medicaments application such as steroids (54). The Committee considered that although this procedure is rarely indicated, deletion of this item would force clinicians to use item 45857, which has a much higher schedule fee. The Committee therefore recommends no change to the item descriptor and reducing the schedule fee to be in line with that of arthrocentesis, which is a procedure of similar complexity.

- Item 45857: The Committee recommends changing the item descriptor to be consistent with modern terminology for management of intra-articular procedures in the literature (55). The recommendation to prevent co-claiming of this item with other arthroscopic or open procedures of the temporomandibular joint will reduce inappropriate use of this item for diagnostically low value procedures.
- Items 45755, 45758, 45859, 45961, 45863, 45867, 45869, 45875, 45877 and 45879: The Committee considered these items to be inconsistent with modern practice and representing a great deal of duplication that could be consolidated down into a number of complete medical services.
- 45865, 45871 and 45873: The Committee considers these items to adequately describe current clinical practice.
- The Committee suggested creating a new item for total temporomandibular joint replacement as this procedure is well established, has been used for over 25 years and has been shown to be effective in the literature (56).

7.18 Miscellaneous oral and maxillofacial procedures

Table 49: Item introduction table for items 45882, 45885, 45888, 45891, 45894 and 45939

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser.	$43.00	182	$5,712.45	5.1%
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.)	$443.70	164	$22,019.90	48.1%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45888	Foreign body, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)	$413.55	22	$6,809.25	-23.9%
45891	Single-stage local flap where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.)	$602.45	6	$2,259.25	-14.3%
45894	Free grafting, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.)	$204.70	28	$2,217.50	22.9%
45939	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Anaes.) (Assist.)	$447.10	4	$1,341.40	-26.0%

7.18.1 Recommendation 56

- Items 45882, 45888 and 45891: No change.
- Item 45885: Delete.
- Item 45894: Change the item descriptor to specify use in the oral cavity.
    - The proposed item descriptor is as follows:
        - Free grafting, in the oral cavity, (mucosa or split skin) of a mucosal defect (Anaes.)
- Item 45939: No change.

7.18.2 Rationale for Recommendation 56

This recommendation is based on enabling clinicians to appropriately select and claim item numbers and bringing the Schedule into line with the Complete Medical Service concept.

- Items 45882, 45888, 45891 and 45939: The Committee considered these items clinically relevant and requiring no change.
- Item 45885: This procedure is never performed in isolation and is always an integral part of other procedures (such as a neck dissection or parotidectomy), as evidenced by the co-claiming data. Items covering these procedures were written with the intent that ligation of these vessels would be included, rendering item 45885 obsolete. The Committee considered this item to be

inconsistent with the Complete Medical Service concept and agreed that it should never have been generated as a separate item.

- Item 45894: The recommendation to specify item use to the oral cavity is based on reducing duplication and overlap with skin item numbers and simplifying the Schedule.

7.19 Maxillofacial fractures and disclocations

Table 50: Item introduction table for items 45823, 45900, 45945, 45975, 45978, 45981, 45984, 45987, 45990, 45993, 45996, 47000, 47735, 47738, 47741, 47753, 47756, 47762, 47765, 47768, 47771, 47774, 47777, 47780, 47783, 47786 and 47789

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45823	Arch bars, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)	$108.90	31	$2,224.95	-5.9%
45900	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$241.15	19	$1,493.70	13.7%
45945	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$118.70	-	$0.00	-
45975	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	$129.20	70	$5,911.45	32.7%
45978	Mandible, treatment of fracture of, not requiring splinting	$157.85	18	$2,159.10	3.7%
45981	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$85.65	34	$1,685.15	11.2%
45984	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.)	$616.65	10	$3,610.40	-28.4%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45987	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)	$616.65	1	$115.65	-36.9%
45990	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)	$842.25	87	$47,809.40	2.5%
45993	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)	$842.25	118	$64,981.25	2.6%
45996	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$238.80	9	$830.25	-5.6%
47000	Mandible, treatment of dislocation of, by closed reduction (Anaes.)	$70.65	49	$2,880.10	0.8%
47735	Nasal bones, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance	$43.05	86	$2,990.45	-6.1%
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$235.50	1,300	$217,889.68	-2.7%
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)	$480.35	82	$24,823.65	-0.7%
47753	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$406.65	11	$2,208.15	0.0%
47756	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$406.65	32	$6,249.95	3.5%
47762	Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	$238.80	36	$5,793.00	-8.1%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
47765	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.)	$392.10	55	$10,872.25	10.1%
47768	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	$480.35	48	$11,795.20	1.3%
47771	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	$551.85	44	$13,659.00	-2.9%
47774	Maxilla, treatment of fracture of, requiring open operation (Anaes.) (Assist.)	$435.65	11	$2,755.60	9.5%
47777	Mandible, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	$435.65	1	$230.20	-12.9%
47780	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$566.35	1	$424.85	-24.2%
47783	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$566.35	1	$212.40	-27.5%
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$718.75	24	$11,047.60	-9.7%
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$718.75	36	$16,673.00	-10.0%

7.19.1 Recommendation 57

- Item 45823: Change item descriptor to allow for insertion of arch bars or similar.
    - The proposed item descriptor is as follows:

- Arch bars or similar, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)

- Items 45900, 45945, 45975, 45978, 45981, 45984, 45987, 45990, 45993 and 45996: Delete
- Item 47000: Change the item descriptor to specify use in the operating theatre of a hospital and requiring general anaesthesia or intravenous sedation.
    - The proposed item descriptor is as follows:
        - Mandible, treatment of dislocation of, by closed reduction requiring general anaesthesia or intravenous sedation and where performed in the operating theatre of a hospital. (Anaes.)
- Items 47735, 47738 and 47741: No change.
- Items 47753 and 47756: Consolidate these items into one descriptor with no change to the schedule fee.
    - The proposed item descriptor is as follows:
        - Maxilla or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)
- Item 47762: Change item descriptor update terminology and restrict co-claiming with any other item in this Group.
    - The proposed item descriptor is as follows:
        - Zygomatic arch, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach. Not claimable with any other item in this Group (Anaes.)
- Items 47765, 47768 and 47771: Consolidate these three items into one item.
    - The proposed item descriptor is as follows:
        - Zygomaticomaxillary complex / malar, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites. (Anaes.)(Assist.)
- Items 47774, 47777, 47780 and 47783: Delete.
- Item 47786: Change item descriptors to clarify fixation involving one or more plate(s)

- The proposed item descriptor is as follows:
  - Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving one or more plate(s) (Anaes.) (Assist.)

- Item 47789: Change item descriptors to clarify fixation involving one or more plate(s)
  - The proposed item descriptor is as follows:
    - Mandible, treatment of fracture of, requiring open reduction and internal fixation involving one or more plate(s) (Anaes.) (Assist.)
- Create a new item to describe the management of naso-orbital-ethmoidal (NOE) fractures.
  - The proposed item descriptor as follows:
    - Naso-orbital-ethmoidal complex, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites. (Anaes.)(Assist.)

7.19.2 Rationale for Recommendation 57

These recommendations aim to bring Medicare into line with modern surgical practice. The Committee recommends consolidation of a number of items to better describe modern clinical practice, update terminology, remove superfluous descriptors and combine item numbers that are no longer used in practice.

- Item 45823: The Committee considered this procedure to be consistent with modern surgical practice, however recommends including in the descriptor allowance for arch bars or similar as use of Intermaxillary Fixation Screws (IMF) has largely replaced arch bars in practice. IMF Screws are the modern version of arch bars and lead to better outcomes for the patient.
- Items 45900 and 45945: The Committee considered these items inconsistent with modern surgical practice and recommend deletion.
- Items 45975, 45978 and 45981: The Committee considered that there is no rationale for these procedures in any practice and recommend deleting these items to avoid honest misinterpretation of the Schedule.
- Items 45984, 45987, 45990, 45993 and 45996: The Committee considered that these items are essentially duplicates of the orthopaedic fracture items and are worded inconsistently with modern practice and therefore consider deletion appropriate.

- Item 47000: The Committee observed the high use of this item by General Practitioners (approximately 77 per cent in FY2016/17) and considered it unlikely that these procedures involve anaesthesia. This indicates that item 47000 is potentially being claimed for an examination rather than a formal reduction, which is not the intention of the descriptor. The Committee noted that there can be a grey area between subluxation and true dislocation; however, subluxation is easily reducible without anaesthesia and a true dislocation is more complex and requires general anaesthesia or intravenous sedation. This recommendation to tighten the descriptor is based on preventing misinterpretation of this item for treatment of simple subluxation.
- Items 47735, 47738 and 47741: The Committee considers that these items are consistent with modern clinical practice and therefore require no change.
- Items 47753 and 47756: The Committee considers treatment of fracture of the maxilla or mandible to be equivalent procedures and recommend combining these items in the interest of simplifying the Schedule.
- Item 47762: This recommendation is in line with updating terminology and enabling clinicians to appropriately select and claim item numbers.
- Items 47765, 47768 and 47771: The Committee considered that separate items accounting for fixation at multiple sites with varying schedule fees provide clinicians with a perverse financial incentive to insert a greater number of plates when not clinically indicated. The recommendation to consolidate these items would eliminate this incentive, improve coding and simplify the Schedule.
- Items 47774, 47777, 47780 and 47783: The Committee recommends deleting these items as modified descriptors of items 47786 and 47789 account for modern surgical best practice as open reduction should not be performed without some sort of fixation.
- Items 47786 and 47789: The Committee recommends clarifying in descriptors fixation using one or more plates to be consistent with modern clinical practice.

7.20 Cleft procedures

Table 51: Item introduction table for items 45677, 45680, 45683, 45686, 45689, 45692, 45695, 45698, 45701, 45704, 45707, 45710, 45713 and 45897

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45677	Cleft lip, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$541.35	24	$9,253	8.4%
45680	Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$676.80	6	$3,055	-11.4%
45683	Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$751.85	2	$1,131	-12.9%
45686	Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$887.50	2	$1,385	-12.9%
45689	Cleft lip, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)	$261.75	-	$-	-
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$300.75	18	$2,584	-7.8%
45695	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	$488.75	25	$6,724	4.6%
45698	Cleft lip, primary columella lengthening procedure, bilateral (Anaes.)	$458.75	1	$86	-
45701	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$827.30	4	$2,017	0.0%
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$300.75	2	$282	-16.7%
45707	Cleft palate, primary repair (Anaes.) (Assist.)	$781.95	74	$42,336	-0.5%
45710	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)	$488.75	4	$1,466	5.9%

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45713	Cleft palate, secondary repair, lengthening procedure (Anaes.) (Assist.)	$556.60	4	$1,670	-4.4%
45897	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)	$1,069.10	11	$8,371.55	40.6%

7.20.1 Recommendation 58

- Item 45677: Change the item descriptor to include primary repair of the nasolabial complex.
    - The proposed item descriptor is as follows:
        - Cleft lip, unilateral primary repair of nasolabial complex, one stage, without anterior palate repair (Anaes.)(Assist.)

The Committee also recommends increasing the schedule fee to better reflect complexity of the procedure

- Item 45680: Change the item descriptor to include primary repair of the nasolabial complex.
    - The proposed item descriptor is as follows:
        - Cleft lip, unilateral primary repair of nasolabial complex, one stage, with anterior palate repair (Anaes.)(Assist.)

The Committee also recommends increasing the schedule fee to better reflect complexity of the procedure

- Item 45683: Change the item descriptor to include primary repair of the nasolabial complex.
    - The proposed item descriptor is as follows:
        - Cleft lip, bilateral primary repair of nasolabial complex, one stage, without anterior palate repair (Anaes.)(Assist.)

The Committee also recommends increasing the schedule fee to better reflect complexity of the procedure

- Item 45686: Change the item descriptor to include primary repair of the nasolabial complex.
- The proposed item descriptor is as follows:
    - Cleft lip, unilateral primary repair of nasolabial complex, one stage, without anterior palate repair (Anaes.)(Assist.)

The Committee also recommends increasing the schedule fee to better reflect complexity of the procedure

- Items 45689, 45692, 45695, 45698, 45701, 45704, 45707, 45710 and 45713: No change.
- Item 45897: Change the item descriptor to specify bone grafting and update 'plastic closure' with 'local flap repair'.
    - The proposed item descriptor is as follows:
        - Alveolar cleft (congenital) unilateral, bone grafting of, including local flap closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)

The Committee also recommends an increased schedule fee to be consistent with the complexity of the procedure and allocation of a new item number within the cleft procedures section of the Schedule.

7.20.2 Rationale for Recommendation 58

This recommendation is based on bringing the Schedule into line with modern clinical practice and the concept of the Complete Medical Service.

- Modernisation of practice has meant that nasal repairs are often performed as a part of the cleft lip repair, adding significant time and complexity to these procedures. This means that surgeons require additional training and expertise in order to perform cleft repairs. Whilst only approximately 14 per cent of cleft items were shown to be co-claimed with rhinoplasty items (45632, 45635, 45638, 45639, 45641, 45644 or 45650) the Committee considered that many cleft surgeons may not be co-claiming this component of the procedure as the nasal repair performed at the time of the cleft lip procedure is slightly lower in magnitude than some rhinoplasties. Development of cleft items which incorporate nasal repair elements will bring these items into line with modern clinical practice and the complete medical service concept.

- Items 45677, 45680, 45683 and 45686: The Committee considered these procedures to be inadequately remunerated given the complexity of the procedure and post-operative care burden. Modern cleft repair surgical practices encompass repair of the whole nasolabial complex and not just the lip, as was historically the case. Therefore, the Committee recommends that the remuneration for these items be increased to reflect the complexity of these procedures.
- Items 45689, 45692, 45695, 45698, 45701, 45704, 45707, 45710 and 45713: The Committee considers these items to be consistent with modern clinical practice and therefore recommend no change
- Item 45897: This recommendation to change the item descriptor will modernise terminology and clarify the procedure referred to with this item number. The Committee agreed that the schedule fee of this item should be increased to reflect the complexity of this procedure. The Committee also recommends allocating this item a new number within the cleft procedures section of the Schedule as this is a procedure indicated for those with cleft lip and palate. This recommendation would rationalise the Schedule.
- Overall, cleft surgery is highly complex and is under-remunerated when compared to other items in the Schedule and the Committee recommends increased remuneration of these items.

8. Recommendations: Paediatric items

8.1 Angioma and Arteriovenous Malformation items

Table 52: Item introduction table for items 45027, 45030, 45033, 45035, 45036, 45039, 45042 and 45045

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45027	Angioma, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.)	$120.35	148	$8,943	-6.1%
45030	Angioma (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.)	$129.25	1,239	$121,672	-4.3%
45033	Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)	$240.70	222	$38,430	-1.8%
45035	Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.)	$702.05	85	$42,043	1.5%
45036	Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)	$1,128.05	18	$14,171	-9.7%
45039	Arteriovenous malformation (3 cms or less) of superficial tissue, excision of (Anaes.)	$240.70	87	$13,374	-0.7%
45042	Arteriovenous malformation, (greater than 3 cms), excision of (Anaes.) (Assist.)	$308.40	29	$5,579	3.9%
45045	Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	$308.40	134	$26,121	-0.6%

8.1.1 Recommendation 59

- Create explanatory notes for this section of the Schedule. Notes should include that the Classification of the International Society for the Study of Vascular Anomalies (ISSVA) 2018 can be referred to if there is any doubt from providers as to what is included as a vascular anomaly. Secondly, where a haemangioma (which is a type of vascular anomaly) has been medically treated and there is only a resulting residuum present, the excision would still fall under this set of items, but the item chosen should relate to the size of the residuum and not the size of the original haemangioma.
- Item 45027: Change item descriptor to update terminology.
    - The proposed item descriptor is as follows:
        - Vascular anomaly, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.)
- Items 45030 and 45039: Consolidate these items and update terminology.
    - The proposed item descriptor is as follows:
        - Vascular anomaly of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.)
- Items 45033 and 45042: Consolidate these items and update terminology.
    - The proposed item descriptor is as follows:
        - Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (Anaes.) (Assist.)
- Item 45035: Change item descriptor to clarify indication of item when there is involvement of major neurovascular structures.
    - The proposed item descriptor is as follows:
        - Vascular anomaly, large, deep and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (Anaes.) (Assist.)
- Item 45036: Change item descriptor to clarify inclusion of dissection of cranial nerves and major vessels and involvement of major neurovascular structures.
    - The proposed item descriptor is as follows:

- Vascular anomaly of neck, deep, and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels (Anaes.) (Assist.)

- Item 45045: Change item descriptor to update terminology.
    - The proposed item descriptor is as follows:
        - Vascular anomaly on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)

8.1.2 Rationale for Recommendation 59

This recommendation is based on updating the terminology of the Schedule to reflect modern understanding of the pathology of these conditions. Due to the improved understanding of this group of conditions and the reframing of their classification, it has been possible to combine some items, with a resultant simplification of this section of the Schedule.

- The Committee considered the 2018 ISSVA Classification of vascular anomalies (57) for the nomenclature of the new descriptors.
- The treatment of haemangiomas, which are the commonest subgroup of vascular tumours (which are themselves within the category of vascular anomalies), has been greatly improved by the discovery in the last few years that they are susceptible to beta blockers. The advent of effective medical treatment in this field, whilst not eliminating the need for surgery, may result in a reduction in the number of procedures, and hence the number of Medicare claims.
- Items 45027, 45030, 45033, 45039 and 45042: As well as updating the terminology of these items the Committee considered there to be a number of redundant clauses in the descriptors and suggested deletion of these (for example, excision from breast).
- Based on modern understanding, it is no longer appropriate to separate what historically were called 'lymphangiomas' from 'arterio-venous malformations' as both are a type of vascular malformation, which are in turn a type of vascular anomaly. Hence updating terminology to be consistent with the ISSVA Classification allowed items 45030 and 45033 to be combined with 45039 and 45042 respectively, leading to a simplified and modern Schedule.
- Items 45035 and 45036: The Committee recommends changing this item descriptor to clarify what is intrinsically covered by this item and to prevent co-

claiming of other items when unnecessary and excessive. The Committee considered high claiming rates of this item by general surgeons (approximately 33 per cent in 2016/17) and recommends changes to the descriptor to ensure appropriate use. The Committee considered it important that within the descriptor, both the criteria for the procedure are clear (i.e. that the tumours involve some major nerves and vessels) and that the service described in the descriptor includes the dissection of the muscles, nerves and vessels (i.e. that these cannot be claimed separately with different item numbers). These recommendations are in line with the concept of the Complete Medical Service and increasing robustness against misuse.

- Item 45045: The Committee considered the anatomical sites covered by this item to be a reasonable grouping for the intended purpose of this item and therefore only recommends updating terminology.

8.2 Congenital atresia and microtia of the ear

Table 53: Item introduction table for items 45660, 45661 and 45662

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45660	External ear, complex total reconstruction of, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)	$2,878.75	17	$33,848	-8.1%
45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)	$1,279.45	13	$12,475	0.0%
45662	Congenital atresia, reconstruction of external auditory canal (Anaes.) (Assist.)	$701.30	3	$978	-12.9%

8.2.1 Recommendation 60

- Item 45660: Change the descriptor.
    - The proposed item descriptor is as follows:
        - External ear, complex total reconstruction of, using costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)
- Item 45661: Change the descriptor.
    - The proposed item descriptor is as follows:
        - External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)
- Item 45662: Delete.

8.2.2 Rationale for Recommendation 60

This recommendation represents a simplification of language in the Schedule.

- Item 45660: The Committee agreed that the sometimes only one costal cartilage graft is required for reconstruction, rendering the word multiple obsolete.
- Item 45661: The Committee agreed that 'full thickness' is not required in the item descriptor as full or partial thickness skin grafts can be indicated depending on the individual.
- Item 45662: The Committee agreed that this item should be reducing in use and suggests deletion unless an argument can be made for its retention based on clinical need.

8.3 Surgical Treatment of macrostomia

Table 54: Item introduction table for item 45676

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
45676	Macrostomia, operation for (Anaes.) (Assist.)	$575.30	$1,565	5	10.8%

8.3.1 Recommendation 61

- Item 45676: No change

8.3.2 Rationale for Recommendation 61

- The Committee agrees that item 45676 remains legitimate, is currently being used appropriately and therefore recommend no change.

9. Recommendations: Brachial Plexus items

9.1 Brachial Plexus item

Table X: Item introduction table for item 39333.

Item	Descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$398.55	82	$12,050	9.7%

9.1.1 Recommendation 62

- Item 39333: delete.
- Generate new items which more accurately reflect the procedures performed.

9.1.2 Rationale for recommendation 62

- Brachial plexus surgery is complex and item 39333 has never adequately addressed the nature and variety of procedures performed. Because of the limitations of the original item, the working group found that other items were being used instead for brachial plexus procedures.
- Brachial plexus operations have evolved over time and so the changes proposed in part reflect a modernisation of the schedule.
- In addition, evidence suggests a high degree of variability of coding for these procedures. The newly proposed codes reflect better the concepts of the complete medical service and will reduce variability of item claims between providers. The newly proposed items in fact simplify how these procedures are currently coded in many instances and will allow multiple different techniques to be used without a profusion of item numbers being generated.

9.1.3 Recommendation 63

Procedures for Thoracic Outlet Syndrome

It is proposed that two new items are created for treatment of thoracic outlet syndrome as follows:

- Proposed new item BPTO1:
    - The proposed item descriptor is as follows:
        - "Decompression of the thoracic outlet, primary, for thoracic outlet syndrome, using any approach, including division of scalene muscles, cervical rib and/or first rib resection where performed."
        - Fee considerations will look at existing items for each component currently claimed in order to derive an appropriate fee.
        - The approximate duration of this procedure is 90 minutes to 2 hours.
- Proposed new item BPTO2
    - The proposed item descriptor is as follows:
        - "Decompression of the thoracic outlet, repeat (revision) procedure, for thoracic outlet syndrome, using any approach, including division of scalene muscles, cervical rib and/or first rib resection where performed."
        - Fee considerations will look at existing items for each component currently claimed to derive an appropriate fee, noting that the fee should be 20% higher than BPTO1.
        - The approximate duration of this procedure is 2 to 3 hours.

Procedures for Brachial Plexus Tumours

- Proposed new item BPTO3
    - The proposed item descriptor is as follows:
        - "Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection."
        - The approximate duration of this procedure is 3 to 4 hours.
- Proposed new item BPTO4
    - The proposed item descriptor is as follows:
        - "Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection."
        - The approximate duration of this procedure is 5 to 6 hours.

Procedures for Deficits of the Brachial Plexus

- Proposed new item BPTO5
    - The proposed item descriptor is as follows:
        - "Exploration of the brachial plexus, either supraclavicular or infraclavicular, including any neurolyses performed, and intraoperative neurophysiological recordings but not including reconstruction of elements. (May be used as a standalone item or in conjunction with BPTO8 – BPTO10)"
        - Fee considerations will use comparators of items currently claimed, including existing exploration item plus neurolyses items.
        - The approximate duration of this procedure is 4 to 6 hours.
- Proposed new item BPTO6
    - The proposed item descriptor is as follows:
        - "Exploration of the brachial plexus, both supraclavicular and infraclavicular, including any neurolyses performed, and intraoperative neurophysiological recordings but not including reconstruction of elements. (May be used as a standalone item or in conjunction with reconstruction items BPTO8 – BPTO10)"
        - Fee considerations will use comparators including existing exploration item plus neurolyses items, noting that the fee should be higher than BPT05.
        - The approximate duration of this procedure is 6 to 7 hours.
- Proposed new item BPTO7
    - The proposed item descriptor is as follows:
        - "Exploration of the brachial plexus, posterior subscapular approach, including resection of the first rib +/- second rib, and vertebral laminectomies or facetectomies, where performed and including any neurolyses performed, and intraoperative neurophysiological recordings but not including reconstruction of elements of the plexus and not including spinal instrumentation. (May be used as a standalone item or in conjunction with BPTO1 – BPTO4)"
        - Fee considerations will use comparators including a mixture of spinal table elements (e.g. 101 in spinal report), existing exploration item plus neurolyses items, noting that the fee should be higher than BPT06.

- Conjoint surgeon if performed with Thoracic surgery.
- The approximate duration of this procedure is 2 hours.

- Proposed new item BPTO8a
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, single cord or trunk (e.g. upper trunk), by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), single surgeon."
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure.
    - The approximate duration of this procedure is 2 to 3 hours.

- Proposed new item BPTO8b
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, single cord or trunk (e.g. upper trunk), by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, principal surgeon."
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting complexity and duration of procedure. Fee should be slightly lower than single surgeon's fee, but not substantially so.
    - The approximate duration of this procedure is 2 to 3 hours.
- Proposed new item BPTO8c
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, single cord or trunk (e.g. upper trunk), by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, conjoint surgeon"
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure. Fee should be slightly lower than principal surgeon's fee.

- The approximate duration of this procedure is 2 to 3 hours.

- Proposed new item BPTO9a
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), single surgeon."
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure. Higher value than BPTO8.
    - The approximate duration of this procedure is 3 to 4 hours.

- Proposed new item BPTO9b
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, principal surgeon."
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure. Slightly lower value than BPTO9a.
    - The approximate duration of this procedure is 3 to 4 hours.
- Proposed new item BPTO9c
  - The proposed item descriptor is as follows:
    - "Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, conjoint surgeon."
    - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure. Lower value than BPTO9b.
    - The approximate duration of this procedure is 3 to 4 hours.

- Proposed new item BPTO10a
    - The proposed item descriptor is as follows:
        - "Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), single surgeon."
        - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure.
        - The approximate duration of this procedure is 4 to 5 hours.
- Proposed new item BPTO10b
    - The proposed item descriptor is as follows:
        - "Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, principal surgeon."
        - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure.
        - The approximate duration of this procedure is 4 to 5 hours.
- Proposed new item BPTO10c
    - The proposed item descriptor is as follows:
        - "Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method (e.g. nerve grafts, vascularised nerve conduit or nerve transfers), conjoint surgery, conjoint surgeon."
        - Fee considerations will use comparators including nerve graft items and other relevant items, noting the complexity and duration of procedure.
        - The approximate duration of this procedure is 4 to 5 hours.

9.1.4 Rationale for Recommendation 63

Procedures on the brachial plexus and thoracic outlet have a high degree of complexity, requiring highly specialised skills and are "high stakes" in terms of being in the region of

major anatomical structures, which if damaged can cause severe complications. In addition, many such procedures take many hours to perform.

The MBS has not so far had adequate coding for the procedures currently practiced. There is therefore a high degree of variability in items claimed for the same procedure, giving patients uncertainty and leaving clinicians with uncertainty about how items should be claimed. This proposal is to generate appropriate “Complete Medical Service” items which align with modern surgical practice and give both surgeons and patients clarity.

It is recognised in modern practice that conjoint procedures have advantages for patients in terms of reduced length of operative procedure and anaesthetic and thus conjoint surgery items are proposed for the most lengthy procedures. Procedures are broadly divided into three, namely, Procedures for thoracic outlet syndrome, procedures for brachial plexus tumours and procedures for brachial plexus deficits.

10. Impact statement

Both patients and clinicians are expected to benefit from these recommendations because they address concerns regarding patient safety and quality of care, and they take steps to simplify the Schedule and make it easier to use and understand. Patient access to services was considered for each recommendation. The Committee also considered each recommendation's impact on provider groups to ensure that any changes were reasonable and fair. However, if the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.

This report represents a genuine effort to reflect up to date, evidence-based surgical practice and presents items in clearly structured way with modern vocabulary.

Particular "big picture" advances that will occur if these recommendations are implemented are as follows:

- Burns surgery will be properly coded for the modern practice of using multiple surgeons and employing skin substitutes.
- Breast cancer surgery and post-mastectomy breast reconstruction will be properly coded for the first time in Australia. This is outlined in more detail below.
- The coding of Oromaxillofacial and Craniomaxillofacial Surgery will be brought into the modern era. This will assist in predictability and consistency of costs and reduce confusion in surgeons trying to code procedures.
- The omitted items from the Skin Services Review and related items like skin graft items will have been rationalised, generating a comprehensive and systematic group of items which will serve the population well in providing consistency and predictability.
- Medicare will be robust against cosmetic misuse.

Overall the Committee's recommendations will benefit patients by guiding best practice and improving billing transparency. Recommendations to tighten, clarify and update item descriptors and to delete and consolidate items will benefit clinicians by simplifying the Schedule. The changes proposed in this report reflect careful consideration of access to services by patients, cost effectiveness and modernisation of clinical practice.

Particular themes of importance in this review are the need to be able to safeguard access to services which are high value, such as skin cancer surgery and skin grafting, but also procedures such as cleft lip and palate repair. Currently these procedures are remunerated at a level that is barely at cost, which has an implication for access to care. If procedures are not remunerated at a level that covers costs, surgeons are less likely to prioritise these cases, or otherwise may need to charge an additional fee, which may not be within the reach of the patient. Similarly, private hospital banding is often linked to item number fees and surgeons performing those procedures that are poorly remunerated by Medicare may be excluded from some private hospital operating suites. This again has implications for access for patients.

This review has diligently looked for areas where inappropriate use of items may be occurring and has addressed these issues. The savings gained from this process should be directed to increasing remuneration in high value areas such as skin cancer surgery, cleft lip and palate, bilateral breast reduction and post-mastectomy breast reconstruction.

It is hoped that the implementation of these recommendations will result in better predictability for patients, improved ease of understanding for providers and a robust Schedule, particularly protected against misuse in the context of cosmetic surgery.

Breast Cancer Surgery and Reconstruction Working Group

Breast cancer surgery and post-mastectomy reconstruction is an area of surgery where many techniques have been developed in the decades since the items were first introduced. The main goal of the Working Group in making its recommendations is to promote patient access to modern procedures that are proven to generate good patient outcomes.

The suite of proposed changes aim to reflect current clinical practice by updating existing items with modern terminology and techniques, and removing obsolete items where appropriate. The Working Group has also recommended introducing specific items for breast reconstruction which are covered inconsistently under various general MBS items. This will enable much greater predictability of costs for patients and will allow a proper evaluation of rates of breast reconstruction, service patterns across Australia and access to this surgery.

In addition, there is a general recommendation to introduce bilateral versions of existing unilateral items to reflect the fact that more patients are now having both breasts treated at the same time, and to simplify billing for patients and providers.

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12. Glossary

Term	Description
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, "change" describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
FY	Financial year
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.

Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Services average annual growth	The average growth per year, over five years to 2016/17, in utilisation of services. Also known as the compound annual growth rate (CAGR).
The Committee	The Plastic and Reconstructive Surgery Clinical Committee of the MBS Review
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2016/17 unless otherwise specified.

Appendix A Summary for consumers

This table describes the medical service, the recommendations of the clinical experts and why the recommendations have been made.

This section is a summary of the main recommendations that the Committee will make to the Taskforce regarding the 288 MBS items in its area of responsibility. These recommendations are based on clinical expertise and rapid evidence review. To inform the recommendations, the Committee has considered MBS data on the types of services used and the amount they are used; appropriate and inappropriate co-claiming behaviour by clinicians; and relevant published literature.

Of the 288 items in scope, the Committee has recommended amending 109 items, deleting 98 items and creating 71 new items. Due to the large volume and highly technical nature of the recommendations, this section focuses on the key recommendations. Broadly, there have been three types of recommendations: amend item descriptors and/or fees, delete items, or add new items. The following table details the type of recommendation, the reason for the recommendation and the result of the recommendation. If consumers require further detail, they can refer to the corresponding section in the report.

Main Recommendations for General/skin items

Item	What it does	Committee recommendation	What would be different	Why
Lipectomy items (30165, 30168, 30171 & 30172)	These items refer to a surgical operation to remove loose skin and extra fat left after someone has lost a large amount of weight. The loose skin and extra fat can affect many aspects of a patient's daily life.	Remove the requirement for a three month trial of nonsurgical treatment before a patient is able to access Medicare funding for lipectomy. Remove the requirement for a patient to suffer from a painful and chaffing rash as a result of rubbing of loose skin and extra fat before they are able to access Medicare funding for this procedure.	Patients will be able to access Medicare funding for this this procedure earlier and for a wider range of reasons. Patients who would benefit from this procedure will still be able to access nonsurgical treatment.	Loose skin following massive weight loss is a serious health problem and the Committee considered the current requirements for patients to be able to access Medicare funding for this procedure to be unreasonable. Loose skin folds can cause disability with respect to employment, exercise, deformity and hygiene and can also lead to weight regain. This recommendation will also improve patient outcomes as patients will not be required to suffer undue hardship while exploring nonsurgical treatment options before being able to access Medicare funding for surgical treatment.

Item	What it does	Committee recommendation	What would be different	Why
Multiple General/Skin services items (Increase consistency and clarity of billing)		Simplify and restructure the MBS by combining (consolidating) items with each other, as well as making clear for what uses items can be claimed and encouraging modern best practice.	Today, many items in the MBS describe similar (and sometimes interchangeable) and unclear procedures, which are sometimes subject to different reimbursement rates. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will standardise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. They will also simplify billing practices for clinicians.	Transparency and equity of care and reimbursement are important values that should be encouraged by the MBS. Consolidating items to reflect clinical best practice ensures that items are available for reasonable and specific procedures, as well as providing billing consistency and clarity for patients.
Multiple General/Skin services items (Exclude cosmetic use)		Modify the MBS to ensure appropriate use of items, specifically excluding use for cosmetic purposes.	There are a number of items in the current MBS which are potentially open to abuse for uses which should not be covered by the MBS, specifically cosmetic procedures. Protecting the MBS from misuse will allow for these items to be used when clinically indicated and not for cosmetic purposes. This will protect the MBS for the future and enable patients requiring these procedures to fairly and simply access necessary services.	Equity of care and maintaining a Schedule that is fit for purpose are important values that should be encouraged by the MBS. Providing clarity regarding when these items should be used ensures appropriate use of the MBS and better reflects current clinical best practice.

Item	What it does	Committee recommendation	What would be different	Why
Multiple General/skin services items (Separate out breast reconstruction services)		Modify the current MBS and move items for breast reconstruction after breast cancer surgery into a separate section of the MBS specific to breast reconstruction.	At present, there are a large number of items being used in the context of breast reconstruction following breast cancer surgery procedures. These are often unclear and inconsistent, resulting in variable billing for patients receiving very similar care. Following the review and recommendations of the breast cancer surgery and reconstruction working group the Committee felt it was sensible to restrict the use of a number of general and skin items to exclude breast reconstruction.	Items that specifically relate to breast reconstruction after breast cancer have been removed from this section to ensure that procedures are clearly defined and accounted for in the MBS. These changes will simplify the Schedule and encourage appropriate use of these items.
Scar revision items (including abrasive therapy) (45021, 45024, 45515 & 45518)	These procedures are used to treat scarring, either by: * a process similar to sanding (abrasive therapy) where the scar becomes less obvious as the skin heals or; * cutting out the scar and repairing with one or more layers of stitches to produce a thinner, less noticeable scar.	Modify these items to ensure appropriate use, excluding scarring resulting from previous cosmetic surgery and the insertion of breast implants for cosmetic purposes. Consolidate the two abrasive therapy items into one and restrict claiming to once per patient per episode.	These changes will minimise the potential for cosmetic misuse of these items and encourage best clinical practice. Currently, there are two abrasive therapy items on the MBS to treat either one specific area of the face, or more than one area. This consolidation will mean that clinicians are reimbursed the same amount for the treatment of the one area of the face and the whole face.	Equity of care and maintaining a Schedule that is fit for purpose are important values that should be encouraged by the MBS. Both Committee members and the published literature suggest that abrasive therapy is rarely used today as it has largely been replaced by laser therapy. However, abrasive therapy may sometimes be beneficial to patients. These changes will encourage clinicians to use modern best clinical practice, leading to improved outcomes for patients.

Item	What it does	Committee recommendation	What would be different	Why
Free grafting split skin items Direct and indirect flap items	These procedures use skin from a healthy part of the body (the donor site) to enable an injured area of skin to heal correctly with minimal discomfort and lasting effects. Split skin grafting procedures involve taking a thin piece of normal skin from a healthy part of the body and placing it on the injured area. Flap surgery is more complex than skin grafting as it involves tissue from a healthy part of the body being moved to a recipient site while still attached to the original site by an intact blood supply.	Consolidate split skin graft items into two new items for small and large defects. Simplify and rationalise the MBS by combining (consolidating) some flap items while allowing for multistaged procedures to improve patient outcomes, as well as clarifying appropriate use and encouraging modern best practice.	The current Schedule includes a number of terms and procedures no longer consistent with modern best clinical practice. Some procedures were historically used; however, have now been largely replaced by modern techniques. Today, many items in the MBS describe similar (and sometimes interchangeable) procedures, which are sometimes subject to different reimbursement rates. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will standardise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. They will also simplify billing practices for clinicians.	Equity of care, transparency and maintaining a consistent Schedule that is fit for purpose are important values that should be encouraged by the MBS. The recommended changes more accurately reflect modern clinical best practice and will provide clinicians with a simplified Schedule to ensure clarity and consistency with appropriate billing for patients. They will also simplify and modernise the MBS Schedule.

Item	What it does	Committee recommendation	What would be different	Why
Microvascular procedures	Microvascular surgery involves procedures to join, repair or reconnect blood vessels (arteries & veins) and nerves during reconstructive surgery. Reconstructive surgery involves transferring muscles and large segments of skin, fat and bone to restore the structure or function of the body part to normal. These procedures are used to treat major conditions resulting from birth defects, surgery or injury.	Simplify and rationalise the MBS by combining (consolidating) items with each other, as well as clarifying indications and encouraging modern best practice. Create a new item to allow for a single surgeon to treat major conditions when appropriate.	At present, many of these items are claimed inconsistently for procedures which may be very similar. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will standardise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. They will also simplify billing practices for clinicians.	Equity of care, transparency and maintaining a Schedule that is fit for purpose are important values that should be encouraged by the MBS.
Lipoma items	Lipomas are benign (noncancerous) tumours of fatty tissue which occur when a lump of fat starts to grow in the soft tissue of the body.	Include lipomas in the descriptors of relevant items and create two new items to allow MBS funding for removal of a single, small lipoma and large and difficult lipomas.	The current MBS does not allow for the reimbursement of the removal of many sizes and quantities of lipomas. These changes will ensure the removal of lipomas is adequately funded by the MBS.	Treatment of lipomas, either multiple or single, is important for patient care and was unintentionally removed from the MBS during a previous review. These changes would ensure the MBS remains fit for purpose and allow patients access to effective and timely treatment when required.

Item	What it does	Committee recommendation	What would be different	Why
New items - very extensive skin cancer	Skin cancer is the uncontrolled growth of abnormal skin cells. It is the most common of all cancers and Australia has the highest incidence of skin cancer in the world. More than two-thirds of the Australian population will develop a skin cancer of some kind during their lives.	Create new items to provide for surgical removal of rare and very extensive skin cancers.	Currently, the MBS does not allow for adequate reimbursement for the removal of very extensive skin cancers. These changes will allow MBS funding for removal of very extensive skin cancers.	The removal of very extensive skin cancers was unintentionally omitted from the MBS during a recent review. To provide encouragement for clinicians to increase their skills and knowledge in this area as this is an area of particular importance in Australia. These changes will improve access to effective care for patients and ensure the MBS remains fit for purpose and allows patients access to effective and timely treatment when required.

Main recommendations for Burns items

Item	What it does	Committee recommendation	What would be different	Why
Multiple burns items	A burn is damage to the skin or other body parts caused by extreme heat, flame, contact with heated objects or chemicals. Treatment depends on depth, surface area and location of the burn, as well as other factors.	Classify burns according to percentage of total body surface area affected, with or without involvement of hands or face. Classify procedures to treat burns as removing affected tissue and closing of the wound at the same time, or closing the wound at a later time when clinically indicated. Allow for use of skin substitutes in the treatment of burns. Restrict claiming by oncologists (doctors who treats cancer) to treat skin reactions as a side effect of radiological treatment (sometimes called radiotherapy burns). Exclude aftercare from burns treatment items and allow clinicians to claim consultation or dressing items as appropriate during the aftercare period.	Today, the burns items in the MBS are confusing and impractical, resulting in different reimbursement rates for patients. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will simplify, standardise and modernise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. The changes will encourage clinical best practice by allowing for the MBS funding of the use of skin substitutes. This overhaul of items will simplify and clarify the Schedule in order to provide a more consistent service to patients and provide for the future.	The Committee considered the current burns items included in the Schedule as impractical and inconsistent with modern best practice. Simplicity, transparency and equity of care and reimbursement are important values that should be encouraged by the MBS. Care and treatment of burns is complex and can occur over several stages. The recommended changes reflect modern best surgical practice and classification of burns in relation to the surface area of the body affected and type of treatment provided. The proposed changes ensure improved clarity in relation to the service being provided and therefore consistency in billing for patients.

Main recommendations for Cranio-maxillofacial/Oral and Maxillofacial Surgery items

Item	What it does	Committee recommendation	What would be different	Why
Multiple Cranio-maxillofacial / Oral and Maxillofacial Surgery items	These items refer to a broad range of procedures relating to birth defects or acquired deformities (change in the normal size or shape of a body part as a result of an injury, infection or tumour) of the head, skull, face, neck, mouth, jaws and/or teeth.	Simplify and rationalise the MBS by combining (consolidating) items with each other, as well as deleting those which are inconsistent with modern best practice.	Today, many items in the MBS describe similar (and sometimes interchangeable) and unclear procedures, which are sometimes subject to different reimbursement rates. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will standardise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. They will also simplify billing practices for clinicians.	Transparency and equity of care and reimbursement are important values that should be encouraged by the MBS. Consolidating items to reflect clinical best practice ensures that items are available for reasonable use, as well as billing consistency and clarity for patients.

Item	What it does	Committee recommendation	What would be different	Why
Multiple Cranio-maxillofacial / Oral and Maxillofacial Surgery items		Modify and clarify items in the MBS to ensure appropriate use of items, specifically excluding use for cosmetic purposes.	There are a number of items in the current MBS which are potentially open to abuse for uses that should not be covered by the MBS, including cosmetic use. Protecting the MBS from misuse will allow for these procedures to be used when appropriate and not for solely cosmetic purposes. This will protect the MBS for the future and enable patients requiring these procedures to equitably and simply access clinically relevant services.	Equity of care and maintaining a Schedule that is fit for purpose are important values that should be encouraged by the MBS. The recommended changes more accurately reflect clinical best practice and ensure that treatment is provided when appropriate rather than being used to fund cosmetic procedures, which is not the intention of the MBS.
Mandible, maxilla and midfacial osteotomy items (45720-45754)	An osteotomy is any surgery that involves precisely cutting a bone. These surgical operations reposition jaw fragments, reshape, realign or modify the mandible and maxilla of the jaw and use fixation (hold them in position with bone screws and/or plates).	Combine 14 items into nine new, simplified and more consistent items, including fixation for each. Create new items for single surgeons and surgeons operating together as appropriate.	Current items are complex and include options to perform osteotomies without fixation, which is not appropriate in current clinical practice. The new items account for and encourage current best surgical practice.	Using fixation in osteotomy procedures is clinical best practice and ensures patients are being treated consistently and according to best clinical practice. The recommended changes reflect clinical best practice and promote clarity in relation to consistent and accurate billing for patients.

Item	What it does	Committee recommendation	What would be different	Why
Surgery for various orbital dystopias, including hypertelorism, syndromic and unilateral/vertical (45767, 45770, 45773, 45776 & 45779)	In these conditions the eyes are not in the correct position; either too far apart and/or not in line with each other. Surgical procedures are required to correct these conditions, which people are often born with (congenital deformities).	Update descriptors to clarify and align with current best clinical practice, as well as deleting items that are obsolete and no longer consistent with best practice.	Currently, these items are inconsistent with modern terminology and best clinical practice. These recommendations clarify correct modern procedures for treatment and allow for correcting/rebuilding of facial bones through use of bones taken from any healthy part of the body (donor site), as opposed to historically where these were taken only from the rib or hip.	Although these are rare conditions it is important that they are aligned with modern best clinical practice. The updated items will enable best clinical practice and ensure that these conditions are appropriately treated and patients have access to surgical procedures which will improve their appearance.
Osseo-integration procedures (45845, 45847, 45794 & 45797)	Insertion of an artificial implant (usually titanium) in the mouth, jaws or face to fix a deformity.	Allow MBS funding for insertion of an artificial implant to treat trauma and congenital disorders (birth defects) of the mouth, jaws or face.	Currently MBS funding of osseo-integration procedures is not available for patients who have had a significant injury (e.g. a gunshot wound to the face) or for those with rare craniofacial disorders where structures supporting the teeth are missing at birth. These changes would ensure that patients who will benefit from these procedures will have access to MBS funding.	Equity of care and access to effective treatment are values which should be encouraged by the MBS. These changes will make the MBS fit for purpose. The recommended changes ensure that patients have equitable access to clinically indicated procedures which will benefit patients.

Item	What it does	Committee recommendation	What would be different	Why
Surgery for osteomyelitis (45815, 45817 & 45819)	Surgical treatment of inflammation (usually caused by infection) of bone.	Delete items inconsistent with modern best surgical practice and modify the descriptor of the remaining item to ensure its use in the facial region only.	These recommendations would require clinicians to prove the presence of osteomyelitis prior to surgery, which will ensure patients are effectively treated for this infection. Deletion of two items for this condition in this section of the MBS will encourage clinicians to refer patients to a neurosurgeon when required for the treatment of osteomyelitis of the skull.	These recommendations will ensure that patients are treated in the safest and most effective manner by the most appropriate clinicians to provide these complex procedures. The recommended changes clarify appropriate use and promote clinical best practice.
Temporomandibular joint disorders	The jaw joint (temporomandibular joint) is a complex structure located in front of the ear. This joint allows the mouth to open and close, and move from side to side. Treatment may range from conservative dental and medical care to complex surgery.	Delete obsolete items and those inconsistent with modern clinical practice. Clarify use of items to allow for clinical best practice. Create a new item for total temporomandibular joint replacement.	The current temporomandibular joint disorder items are complex, largely duplicated and inconsistent with modern clinical practice. These changes will update the MBS to make it fit for purpose and in line with current clinical practice.	Equity of care, transparency and access to effective treatment are important values that should be encouraged by the MBS. The recommended changes reflect clinical best practice and promote clarity in relation to consistent and accurate billing for patients.

Item	What it does	Committee recommendation	What would be different	Why
Maxillofacial fracture and dislocation items	Treatment of fractures and dislocations in the mouth, jaws and face.	Modify and combine items, as well as delete those inconsistent with modern best practice. Update descriptors and encourage appropriate use, to be in line with current clinical practice. Encourage best practice by specifying the use of fixation (using screws and plates to hold the bones stable) for the treatment of fractures of various facial bones.	Today, many items in the MBS describe similar (and sometimes interchangeable) procedures, which are sometimes subject to different reimbursement rates. This means that two patients might receive very similar care but see different procedures on their bills and be reimbursed different amounts. These recommendations will standardise care provision so that similar procedures fall under the same transparent item description and receive the same reimbursement, all other things being equal. They will also simplify billing practices for clinicians.	Transparency and equity of care and reimbursement are important values that should be encouraged by the MBS. The recommendation to specify the use of fixation is important to bring these items into line with current best clinical practice. Modifying these descriptors also ensures appropriate selection of items and clarity of billing.

Item	What it does	Committee recommendation	What would be different	Why
Cleft procedure items	A cleft is a common birth defect where the two halves of the palate and/or lip fail to fuse properly in early development, leaving an open space or 'cleft'. A cleft can occur in the roof of the mouth (palate) or between the two halves of the lip. Surgery is required to treat these conditions.	Increase fees and change item descriptors to clarify the level of complexity of these procedures. Include in multiple descriptors reshaping and repair of the nose at the same time as the cleft repair to improve appearance and/or function.	Currently, a number of these items do not allow MBS funding for reshaping and repair of the nose, despite this often being performed in the same operation as cleft repair. Changes to these items will ensure clinicians are encouraged to perform repairs in the one operation and encourage specialisation in this area, which will improve the service available to consumers.	Surgical operations to correct clefts have evolved over time and these recommendations will reflect what has occurred in current clinical practice. Correction of defects of the nose are now treated in the same procedure and the Committee felt it reasonable to allow MBS funding for these procedures to promote best practice and avoid multiple different surgeries. Modifying these descriptors ensures appropriate selection and clarity of billing for patients.

Main recommendations for Paediatric items

Item	What it does	Committee recommendation	What would be different	Why
Multiple paediatric items	Treatment of clinical conditions specific to children which are within the scope of plastic and reconstructive surgeons. These include: birthmarks; noncancerous tumours (abnormal growth of tissue); lesions made up of blood vessels that have not developed normally; abnormal connections between arteries and veins; larger than average newborns; abnormally narrow ear canal and underdeveloped ears.	Update terminology, clarify use and consolidate items into simplified descriptors which are consistent with international terminology.	Today, the paediatric items in the plastic and reconstructive surgery section of the MBS are confusing and inconsistent with international standards and terminology. These recommendations will simplify, standardise and modernise care provision so that similar procedures fall under the same transparent item description and patients will receive the same reimbursement, all other things being equal.	Equity of care and access to effective treatment are values which should be encouraged by the MBS. These changes will make the MBS fit for purpose into the future.

Appendix B

Letters regarding the Medical Service Concept and three item rule

Dear Prof Robinson / PRC,

The Plastic and Reconstructive Surgery Clinical Committee is making good progress. We are endeavouring to use all the Principles of the principles and Rules Committee and understand the focus on the complete medical service and the 3 item rule. I am writing to ask for an assurance in writing that in the circumstance where a patient has multiple skin cancers or other multiple pathologies in different sites (e.g. melanoma on the scalp, BCC on the leg and SCC on the hand) that each site / pathology will be considered a separate procedure for the purposes of the 3 item rule and will hence be able to be claimed with up to 3 items.

Both you and Prof Michael Besser have given me verbal assurance that this is the case, but it is such an important point, for a very common scenario, that our committee requires a written confirmation of this stance.

Thankyou

Kind regards

Nicola Dean

31 August 2018

Dr Nicola Dean

Chair

Plastic and Reconstructive Surgery Clinical Committee

Dear Dr Dean

Medicare Benefits Schedule (MBS) Review—The 'complete medical service' and three-item rule

I am writing to you in my capacity as Chair of the MBS Review Taskforce's Principles and Rules Committee (PRC), in response to your request for written confirmation of the acceptability of your proposed approach to the definition of a 'complete medical service' for application to the Taskforce's recommended three-item rule.

The clinical situation you describe in your letter clearly involves distinctly different pathologies in different anatomical locations. On behalf of the PRC, I can confirm that the treatment of each of these should be construed as separate procedures—i.e. complete medical services—and that it would be permissible under the Taskforce's proposed approach to claim up to three MBS items for each.

I trust this letter addresses your concerns.

Yours sincerely

Professor Michael Grigg

Chair, MBS Principles and Rules Committee

5 September 2018

Appendix C Breast Cancer Surgery and Reconstruction expanded Consumer Summary

Recommendation: Breast Cancer surgery and Reconstruction items

Item	What it does	Committee recommendation	What would be different	Why
Multiple items (31519, 31524, 45527, 45530, 45539, 45542, new items for microsurgery)	Items will clearly show whether they are for treatment of one breast or both	Amend existing items and introduce bilateral versions of unilateral items	There will be no difference to the services provided but these changes will simplify billing clarity.	Currently patients requiring bilateral procedures (for both breasts) would be billed twice. Introducing new bilateral items will more accurately reflect that patients are having both breasts treated.
30299 and 30300; 30302 and 30303	Sentinel lymph node biopsy of the axilla (lymph nodes in the armpit region) to provide information about spread of the cancer	Simplify the MBS by amending and combining items	Patients will receive the same care as they do currently. The changes will simplify billing practices for providers and explain the bill to consumers.	Currently there are separate items depending on the level (location/how much) of the lymph nodes removed. As there is no significant difference between the procedures carried out in each case, it is recommended to merge these items for simplicity.
New item	Sentinel lymph node biopsy of the internal mammary chain (lymph nodes on either side of the breastbone) to provide information about spread of the cancer	Create a new item for sentinel lymph node biopsy of the internal mammary chain	The biopsy would provide more information to decide subsequent treatment options. The small number of patients who require this service will have access to a Medicare rebate.	This service, by providing more information about the spread of cancer in a particular group of breast cancer patients, helps to inform decision making for follow-up treatment.

Item	What it does	Committee recommendation	What would be different	Why
30332, 30335 and 30333	Surgical removal of lymph nodes	Simplify the MBS by amending and combining items	Patients will receive the same care as they do currently. The changes will simplify billing practices for providers and explain the bill to consumers.	The procedures can be more simply defined as 'limited' or 'complete' to be consistent with current clinical practice.
31539, 31545	Biopsy of a tumour or tissue of the breast using specific equipment	Delete items	No change for patients. These items have not been used for a number of years.	These items are being removed as they are now obsolete and no longer consistent with current clinical practice.
New items	Oncoplastic breast surgery (removing cancerous tissue in a way that also results in good cosmetic outcomes)	Create two new items for removal of cancerous tissue in the breast using oncoplastic techniques to also achieve good cosmetic outcomes	Currently patients have this service claimed under various combinations of MBS items. The new items will clearly describe the services being performed, simplify billing for providers, and explain the fee to patients.	Oncoplastic breast surgery focuses on removing cancerous tissue while also optimising cosmetic outcomes, and is increasingly being utilised in clinical practice. This recommendation modernises the MBS to reflect current practice in breast cancer surgery.
31524 New item	Subcutaneous mastectomy (removal of breast tissue under the skin)	Replace with new items for nipple sparing and skin sparing mastectomy	There will be no change for patients but the new items will more accurately describe the procedures being performed today.	'Subcutaneous mastectomy' is a historical term which does not accurately describe modern surgical practice for a mastectomy where the patient's skin is not removed. This recommendation will update the MBS to reflect current practice.
31525	Mastectomy for gynecomastia (benign enlargement of breast tissue in males)	Amend item and require photographic evidence to be kept in patient notes	Patients will receive the same care as they do currently. The changes specify that doctors should keep photographs on record.	Photographic evidence is easy to capture and will help ensure doctors are using this item appropriately.

Item	What it does	Committee recommendation	What would be different	Why
31563	Surgical correction of an inverted nipple (where the nipple is retracted below the level of the surrounding skin)	Amend item	Patients will receive the same care as they do currently. The changes will simplify billing practices for providers and explain the bill to consumers.	This amendment clarifies for providers that this item is intended to cover all components of correction surgery, including flap repair (where skin and tissue is moved from another part of the body to cover a defect) if this is performed.
45527	Breast reconstruction using an implant following mastectomy	Amend item	Wording change only. No change to services performed.	Referring to 'breast reconstruction' in the item descriptor more accurately reflects the services being performed and maintains consistency with other similar items.
45530	Breast reconstruction using autologous flaps (where the patient's own muscles and tissue are moved to the chest)	Amend item	Wording change only. No change to services performed.	There are now more options for which muscles and tissues can be used for breast reconstruction and so there is no need to emphasise reconstruction using the latissimus dorsi (a large back muscle).
45533, 45536	Breast sharing reconstruction (transferring tissue from the other breast)	Delete items and replace with two new items for perforator flaps (where skin and tissue connected to a deep blood vessel is moved from another part of the body)	Patients will receive a more effective and modern treatment.	This procedure is now outdated. These new items describe the current practice of using tissue from another part of the body. This tissue can be used to fill a partial mastectomy (lumpectomy) defect or in preparation for microsurgical reconstruction.

Item	What it does	Committee recommendation	What would be different	Why
New item	Revision of breast reconstruction to approve the appearance of the breast	Create a new item as no specific item currently exists for this procedure	There will be no change for patients. Currently this service is claimed under various MBS items. The new item will clearly describe the service being performed, simplify billing for providers, and explain the fee to patients.	Some patients may require a minor procedure to refine the original reconstruction outcome. This recommendation modernises the MBS to reflect current practice in breast reconstruction surgery.
New items	Microsurgical breast reconstruction (tissue is transplanted to the patient's chest and blood vessels are reconnected using microsurgery)	Create new items for single surgeons and surgeons operating together	Currently this service is claimed under general microsurgical items. The new items will clearly describe the services being performed, simplify billing for providers, and explain the fee to patients.	Microsurgical breast reconstruction is becoming more widely used in clinical practice as it can have benefits for patients in reducing recovery times, reducing scarring and maintaining muscle strength. It is a distinct service and should have separate item numbers from more general microsurgical items.
New item	Covers the lower part of a breast implant (referred to as the lower pole) with the patient's own tissue	Create a new item for lower pole coverage using the patient's own tissue	Currently this service is claimed under general items for local flaps. The new items will clearly describe the service being performed, simplify billing for providers, and explain the fee to patients.	This procedure can result in improved outcomes for implant based reconstruction procedure by reducing the need for subsequent revision surgery.
New item	Covers the lower part of a breast implant with tissue not from the patient (allograft) or a synthetic product	Create a new item for lower pole coverage with allograft or synthetic product	MSAC assessment required	This procedure can result in improved outcomes for implant based reconstruction procedure by reducing the need for subsequent revision surgery.

Item	What it does	Committee recommendation	What would be different	Why
New item	Autologous fat graft by injection (injection of patient's fat to correct contour defects)	Create a new item for autologous fat grafting	MSAC assessment required	Autologous fat grafting can be used to repair defects arising from a partial mastectomy (lumpectomy) or breast reconstruction. It may reduce the need for subsequent revision surgery in suitable patients.
New item	Dissection of a perforator flap	Create two new items, one for a pedicled flap and one for free flap	MSAC assessment required	These new items reflect the modernisation of the MBS. Perforator flaps are an intrinsic part of modern surgical practice and their raising and dissection represent additional workload compared with other flaps, as well as a high degree of skill and training for successful execution.
New item	Performing a free flap with a bony component	Create two new items	MSAC assessment required	The rationale for this item is modernization of the schedule and the need for an appropriate "complete medical service" item for complex reconstruction including vascularized bone.
New item	Procedures for double free flaps with at least one bone component or without bone component	Create four new items, two for the double free flaps with at least one bone component, two for the double free flaps without any bone component.	MSAC assessment required	These changes are in line with the principle of the complete medical service and modernization of the schedule.

Item	What it does	Committee recommendation	What would be different	Why
New item	Reconstruction of the highly complex defects of the maxilla, mandible or skull base	Create a new item	MSAC assessment required	The new item represents the modernisation of the MBS.

Appendix D Assigned items: recommendations list

Item	Abridged current descriptor	Recommendation	Section
30299	SENTINEL LYMPH NODE BIOPSY	Delete	3.1.1
30300	SENTINEL LYMPH NODE BIOPSY	Amend	3.1.1
30302	SENTINEL LYMPH NODE BIOPSY	Delete	3.1.1
30303	SENTINEL LYMPH NODE BIOPSY	Amend	3.1.1
30332	LYMPH NODES of AXILLA, limited excision of	Amend	3.2.1
30335	LYMPH NODES of AXILLA, complete excision of	Delete	3.2.1
30336	LYMPH NODES of AXILLA, complete excision of	Amend	3.2.1
31500	BREAST, BENIGN LESION	No change	3.3.1
31503	BREAST, BENIGN LESION	No change	3.3.1
31506	BREAST, ABNORMALITY	No change	3.3.1
31509	BREAST, MALIGNANT TUMOUR	No change	3.3.1
31512	BREAST, MALIGNANT TUMOUR	No change	3.3.1
31515	BREAST, TUMOUR SITE	No change	3.3.1
31516	BREAST, MALIGNANT TUMOUR	No change	3.3.1
31519	BREAST, total mastectomy	Amend	3.4.1
31524	BREAST, subcutaneous mastectomy	Delete	3.4.3
31525	BREAST, mastectomy for gynecomastia	Amend	3.4.1
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF	Delete	3.3.1
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF	Delete	3.3.1
31551	BREAST, HAEMATOMA	No change	3.5.1
31554	BREAST, microdochotomy of	No change	3.5.1

Item	Abridged current descriptor	Recommendation	Section
31557	BREAST CENTRAL DUCTS, excision of	No change	3.5.1
31560	ACCESSORY BREAST TISSUE, excision of	No change	3.5.1
31563	INVERTED NIPPLE, surgical eversion of	Amend	3.5.1
31566	ACCESSORY NIPPLE, excision of	No change	3.5.1
45497	FLAP, free tissue transfer using microvascular techniques	No change	4.1.1
45498	FLAP, free tissue transfer using microvascular techniques	No change	4.1.1
45499	FLAP, free tissue transfer using microvascular techniques	No change	4.1.1
45527	MAMMAPLASTY, AUGMENTATION, (unilateral)	Amend	4.2.1
45530	Breast reconstruction (unilateral)	Amend	4.3.1
45533	BREAST RECONSTRUCTION	Delete	4.3.1
45536	BREAST RECONSTRUCTION	Delete	4.3.1
45539	BREAST RECONSTRUCTION (unilateral)	No change	4.2.1
45542	BREAST RECONSTRUCTION (unilateral)	No change	4.2.1
45545	NIPPLE OR AREOLA or both, reconstruction of	No change	4.4.1
45546	NIPPLE OR AREOLA or both, intradermal colouration of	No change	4.4.1

Appendix E Breast Cancer Surgery and Reconstruction Items already reviewed

This table outlines the services relevant to breast cancer or reconstruction surgery that were reviewed by the Department of Health in 2016-17. These changes have already been approved by Government and will be implemented on 1 November 2018. The items in Table 13 are out-of-scope for this Working Group and are provided for information only, not for further comment.

Table 55: Items already reviewed and changing on 1 November 2018

Item	Recommendation	Current descriptor	New descriptor
45520	Amend Item	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast
45522	Amend Item	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia	REDUCTION MAMMAPLASTY, without surgical repositioning of nipple, excluding the treatment of gynaecomastia, not with insertion of any prosthesis Note: There will be further changes to items 45520 and 45522 once new items for oncoplastic breast surgery are introduced.
New Item – 45523	New Item	N/A	REDUCTION MAMMAPLASTY (bilateral) with surgical repositioning of nipple, for patients with macromastia and experiencing pain in the neck or shoulder region, not with insertion of any prosthesis (Anaes.) (Assist.) Proposed fee: $1,350.70 (75% benefit = $1,013.05)

Item	Recommendation	Current descriptor	New descriptor
45524	Amend Item	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast	MAMMAPLASTY, AUGMENTATION (unilateral), in the context of breast cancer or developmental abnormality of the breast, for a maximum of one service provided to the same patient on the same occasion. For developmental abnormality, there must be a difference in breast volume of at least: (a) 20% in normally shaped breasts; or (b) 10% in tubular breasts or in breasts with abnormally high inframammary folds, as demonstrated by an appropriate volumetric measurement technique.
45527	Amend Item	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy	BREAST RECONSTRUCTION (unilateral) following mastectomy using a permanent prosthesis
45528	Amend item	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, where it can be demonstrated that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery)	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, where reconstructive surgery is indicated because of developmental malformation of breast tissue (excluding hypomastia), disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery), or for amastia secondary to a congenital endocrine disorder. Sufficient photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service must be included in patient notes.
45548	No change	BREAST PROSTHESIS, removal of, as an independent procedure	N/A
45551	Amend Item	BREAST PROSTHESIS, removal of, with excision of fibrous capsule	BREAST PROSTHESIS, removal of, with excision of at least half of the fibrous capsule (as documented in the histopathology report), not with insertion of any prosthesis
45552	Delete Item (covered by amended 45554)	BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis	DELETE ITEM

Item	Recommendation	Current descriptor	New descriptor
45553	Amend Item Amend Fee	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation).	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material, or symptomatic capsular contracture), where it is demonstrated by on-table photographs post-removal that removal alone would cause unacceptable deformity or where the original implant was inserted in the context of breast cancer or developmental abnormality. Sufficient photographic evidence, both pre-operative and intra-operative demonstrating the clinical need for this service must be included in patient notes $638.65 Amended fee: $571.60 (75% benefit = $428.70)
45554	Amend Item	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material, or symptomatic capsular contracture), where it is demonstrated by on-table photographs post-removal that removal alone would cause unacceptable deformity or where the original implant was inserted in the context of breast cancer or developmental abnormality, including excision of at least half of the fibrous capsule (as documented in the histopathology report) or formation of a new pocket, or both. Sufficient photographic evidence, both pre-operative and intra-operative demonstrating the clinical need for this service must be included in patient notes
45555	Delete Item	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis	DELETE ITEM

Item	Recommendation	Current descriptor	New descriptor
45556	Amend Item	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (H)	BREAST PTOSIS, correction of (unilateral), in the context of breast cancer or developmental abnormality - for a maximum of one service provided to the same patient on the same occasion. Sufficient photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging evidence demonstrating the clinical need for this service must be included in patient notes