



Changes to in and out of hospital benefit for plastic and reconstructive surgery services from 1 March 2024

Last updated: 11 December 2023

What are the changes?

From 1 March 2024, there will be amendments to 14 Medicare Benefits Schedule (MBS) items for plastic and reconstructive surgery services. The amendments include:

- The removal of the 85% out of hospital benefit from items **31344, 31386, 31387, 31388, 45027, 45209, 45562, 45563, 45614, 45671, 45855, 45857, 46092 and 46094.**

Why are the changes being made?

These changes are a result of recommendations of the Plastic and Reconstructive Surgery Implementation Liaison Group (ILG) which was established to provide advice on the implementation of the MBS Review Taskforce recommendations for plastic and reconstructive surgery Items. The ILG identified 14 MBS items that were amended or created as part of the MBS Review of plastic and reconstructive surgery services, that they considered unsafe to be performed out of hospital.

More information about the Taskforce and associated Committees is available at [Medicare Benefits Schedule Review](#) in the consumer section of the [Department of Health and Aged Care website](#).

What does this mean for providers?

From 1 March 2024, Medicare benefits will no longer be payable for professional services performed by a provider for out of hospital treatment under the items specified below. Providers will need to familiarise themselves with the changes set out below, and any associated rules and explanatory notes. Providers have a responsibility to ensure that any services they bill to Medicare fully meet the eligibility requirements outlined in the legislation.

How will these changes affect patients?

From 1 March 2024, Medicare benefits will no longer be payable for professional services rendered to a patient for out of hospital treatment under the items specified below. Patients will receive Medicare benefits for plastic and reconstructive surgery services that are clinically appropriate and reflect modern clinical practice.

Who was consulted on the changes?

As part of the MBS Review, the Plastic and Reconstructive Surgery Clinical Committee was established to make recommendations to the MBS Review Taskforce on MBS items in its area of responsibility. Following the release of the recommendations of the Taskforce and Clinical Committee, the Department of Health and Aged Care convened the Plastic and Reconstructive Surgery Implementation Liaison Group (ILG), to support the implementation of the changes, ensuring that the changes achieved the outcomes intended by the Taskforce and to reduce unintended consequence. The ILG included (but was not limited to) representatives from the Australian Medical Association, Australian Society of Plastic Surgeons and Breast Surgeons of Australia & New Zealand.

How will the changes be monitored and reviewed?

Service use of amended plastic and reconstructive surgery items will be monitored and reviewed post-implementation.

All plastic and reconstructive surgery items will continue to be subject to MBS compliance processes and activities, including random and targeted audits which may require a provider to submit evidence about the services claimed.

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

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health and Aged Care provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the [Department's website](#). Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the [Federal Register of Legislation](#). If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to '[News for Health Professionals](#)' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the [Downloads](#) page.

Amended item descriptors (to take effect 1 March 2024)

Category 3 – Therapeutic Procedures

Group T8 – Surgical Operations

Subgroup 1 – General

31344

Lipoma, removal of, by surgical excision or liposuction, if:

(a) the lesion:

- (i) is subcutaneous and 150mm or more in diameter; or
- (ii) is submuscular, intramuscular or involves dissection of a named nerve or vessel and is 50 mm or more in diameter; and

(b) a specimen of the excised lipoma is sent for histological confirmation of diagnosis

(H) (Anaes.) (Assist.)

Fee: \$695.35 Benefit: 75% = \$521.55 ~~85% = \$596.65~~

Private Health Insurance Classification:

- Clinical category: Skin
- Procedure type: Type B Non-band Specific

31386

Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if:

(a) the lesion is excised from the head or neck; and

(b) the necessary excision diameter is more than 50 mm; and

(c) the excision involves at least 2 critical areas (eyelid, nose, ear, mouth); and

(d) the excised specimen is sent for histological examination; and

(e) malignancy is confirmed from the excised specimen or previous biopsy; and

(f) the service is not covered by item 31387

Category 3 – Therapeutic Procedures

(H) (Anaes.) (Assist.)

Fee: \$786.45 Benefit: 75% = \$589.85 ~~85% = \$667.75~~

Private Health Insurance Classification:

- Clinical category: Skin
- Procedure type: Type B Non-band Specific

31387

Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if:

- (a) the lesion is excised from the head or neck; and
- (b) the necessary excision diameter is more than 70 mm; and
- (c) the excised specimen is sent for histological examination; and
- (d) malignancy is confirmed from the excised specimen or previous biopsy; and
- (e) the service is not covered by item 31386

(H) (Anaes.) (Assist.)

Fee: \$707.70 Benefit: 75% = \$530.80 ~~85% = \$609.00~~

Private Health Insurance Classification:

- Clinical category: Skin
- Procedure type: Type B Non-band Specific

31388

Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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 more than 120 mm; and
- (c) the excised specimen is sent for histological examination; and
- (d) malignancy is confirmed from the excised specimen or previous biopsy

(H) (Anaes.) (Assist.)

Fee: \$636.90 Benefit: 75% = \$477.70 ~~85% = \$541.40~~

Private Health Insurance Classification:

- Clinical category: Skin

Category 3 – Therapeutic Procedures

- Procedure type: Type B Non-band Specific

Subgroup 13 – Plastic and Reconstructive Surgery

45027

Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital **(H)** (Anaes.)

Fee: \$132.50 Benefit: 75% = \$99.40 ~~85% = \$112.65~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type B Non-band Specific

45209

Pedicle flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure **(H)** (Anaes.) (Assist.)

Fee: \$521.50 Benefit: 75% = \$391.15 ~~85% = \$443.30~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type A Surgical

45562

Free transfer of tissue (microvascular free flap) for non-breast defect involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect (if performed), other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies **(H)** (Anaes.) (Assist.)

Fee: \$1,210.10 Benefit: 75% = \$907.60 ~~85% = \$1,111.40~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type A Advanced Surgical

45563

Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, or for genital reconstruction, including:

(a) direct repair of secondary cutaneous defect (if performed); and

(b) formal dissection of the neurovascular pedicle;

other than a service performed on simple V-Y flaps or other standard flaps, such as rotation or keystone **(H)** (Anaes.) (Assist.)

Category 3 – Therapeutic Procedures

Fee: \$1,210.10 Benefit: 75% = \$907.60 ~~85% = \$1,111.40~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type A Advanced Surgical

45614

Eyelid, reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, if unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required **(H)** (Anaes.) (Assist.)

Fee: \$918.05 Benefit: 75% = \$688.55 ~~85% = \$819.35~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type A Surgical

45671

Lip or eyelid reconstruction, single stage or first stage of a two-stage flap reconstruction of a defect involving all 3 layers of tissue, if the flap is switched from the opposing lip or eyelid respectively **(H)** (Anaes.) (Assist.)

Fee: \$918.05 Benefit: 75% = \$688.55 ~~85% = \$819.35~~

Private Health Insurance Classification:

- Clinical category: Plastic and reconstructive surgery (medically necessary)
- Procedure type: Type A Surgical

45855

Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint **(H)** (Anaes.) (Assist.)

Fee: \$319.80 Benefit: 75% = \$239.85 ~~85% = \$271.85~~

Private Health Insurance Classification:

- Clinical category: Bone, joint and muscle
- Procedure type: Type B Non-band specific

45857

Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy (including repositioning of meniscus where indicated)—one or more such procedures of that joint, other than a service associated with any other arthroscopic or open procedure of the temporomandibular joint **(H)** (Anaes.) (Assist.)

Category 3 – Therapeutic Procedures

Fee: \$719.65 Benefit: 75% = \$539.75 ~~85% = \$620.95~~

Private Health Insurance Classification:

- Clinical category: Bone, joint and muscle
- Procedure type: Type B Non-band specific

46092

Lower pole coverage of reconstructive breast prosthesis, following mastectomy, using muscle or fascia turnover flap or autologous dermal flaps, if the service is performed in combination with a service to which item 31522, 31523, 31528, 31529, 45527, 45539 or 45542 applies **(H)** (Anaes.) (Assist.)

Fee: \$446.90 Benefit: 75% = \$335.20 ~~85% = \$379.90~~

Private Health Insurance Classification:

- Clinical category: Breast surgery (medically necessary)
- Procedure type: Type A Surgical

46094

Lower pole coverage or complete implant coverage of reconstructive breast prosthesis, following mastectomy, using allograft or synthetic products **(H)** (Anaes.) (Assist.)

Fee: \$330.20 Benefit: 75% = \$247.65 ~~85% = \$280.70~~

Private Health Insurance Classification:

- Clinical category: Breast surgery (medically necessary)
- Procedure type: Type A Surgical

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.