

## 1 March 2022 changes to Gynaecology items – Explanatory Notes

- From 1 March 2022, some of the Medicare Benefits Schedule (MBS) items for gynaecology services are changing to align with contemporary best practice. The changes are a result of the MBS Review Taskforce recommendations for gynaecology and extensive consultation with stakeholders.
- There will be amendments to 68 items, including the introduction of 13 new items and the removal of 32 items from the MBS. There will be 11 new explanatory notes created and 5 amendments to existing explanatory notes.
- The Department of Health provides an email advice service for providers seeking advice on interpretation of MBS items and rules and the Health Insurance Act and associated regulations. If you have a question regarding the interpretation of the pain management items, please email [askMBS@health.gov.au](mailto:askMBS@health.gov.au).

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## Gynaecology items new and amended explanatory notes

Details of the changes to items referenced in the below explanatory notes can be found in the following factsheets:

- Assisted Reproductive Technology changes
- General Gynaecology changes
- Urogynaecology changes
- Gynaecological changes

### New Explanatory Note: TN.8.230 Hydrotubation (Item 35703)

It is expected that this item should only be billed once per patient per lifetime unless clinically indicated in cases where a successful pregnancy has been achieved following hydrotubation of fallopian tubes or another intervening and documented condition has occurred such a tubal infection, an episode of surgery or conservative treatment of an ectopic pregnancy.

### Amended Explanatory Note: TN.1.4 Assisted Reproductive Technology ART Services (Items 13203, 35631, 35632 and 35641)

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology and Diagnostic Imaging) in lieu of or in connection with items 13200 - 13221. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, **35631, 35632, 35637, 35641**, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, ~~13206~~, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify ~~Services Australia the Department of Human Services~~ of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

**NOTE:** Items 14203 and 14206 are not payable for artificial insemination.

New Explanatory Note: TN.8.229 Appropriate Documentation (Items 35750, 35751, 35753, 35754, 35756, 35631, 35632, 35637, 35641, 35658)

Appropriate documentation, ideally with photographic and/or histological evidence, is to be collected and retained to demonstrate the complexity of the procedure performed. Where photographic evidence is not retained, the reasons for this should be clearly documented.

New Explanatory Note: TN.8.231 Hysterectomy (Items 35750, 35751, 35753, 35754, 35756)

Procedure may be undertaken using laparoscopy with any number of ports or by any approach as clinically indicated.

A laparoscopically assisted vaginal hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and commence the procedure taking the round ligaments, adnexal attachments as indicated and to the level of the uterine arteries with the uterine arteries and uterosacral pedicles secured vaginally.

A total laparoscopic hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and complete the procedure laparoscopically including securing the uterine arteries and uterosacral pedicles.

The complex hysterectomy items 35753 and 35754 are intended to cover procedures with increased complexity. 35753 is to be used for the excision of moderate endometriosis. 35754 is to be used for the excision of extensive endometriosis and when side wall dissection is required.

New Explanatory Note: TN.8.232 Documentation collection (Items 35653, 35661, 35717)

Appropriate documentation is to be collected and retained to demonstrate the complexity of the procedure performed.

Amended Explanatory Note: TN.8.46 Sterilisation of Minors – Legal Requirements (Item 35637)

TN.8.46 Sterilisation of Minors - Legal Requirements - (Items ~~35637, 35657~~, 35687, 35688, 35691, 37622 and 37623)

- (i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.
- (ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.
- (iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973*.

Amended Explanatory Note: TN.8.43 Hysteroscopy (Item 35626)

Hysteroscopy undertaken in ~~outpatient settings, the office/~~consulting ~~suits or offices rooms~~ can be claimed under this item where the conditions set out in the description of the item are met.

Amended Explanatory Note: TN.8.47 Debulking of Uterus (Item 35658)

Benefits are payable under Item 35658, using the multiple operation rule, in addition to ~~vaginal~~ hysterectomy.

New Explanatory Note: TN.8.233 National Cervical Screening Program (Items 35609, 35610, 35614, 35647, 35648, 35723, 35724)

The procedure should only be performed if a patient satisfies the criteria according to the current National Cervical Screening Program.

New Explanatory Note: TN.8.234 Cervical ablation (Item 35644 and 35645)

- Not for use in patients with a type 3 transformation zone.
- A second ablative treatment for a HSIL (CIN2/3) should NOT be performed (an excisional treatment is indicated in this situation).
- Treatment of high-grade lesions (CIN 2/3) in an immunocompromised patients should be by excisional methods only.

New Explanatory Note: TN.8.235 Gynaecological Oncologist or MDT Review (Items 35536, 35548, 35560,35561, 35562, 35564, 35609, 35610, 35647, 35648, 35667, 35668, 35720, 35721, 35723, 35724)

If the procedure is for glandular high grade abnormality or any suspected invasive cancer the procedure should be performed by a gynaecological oncologist or only after discussion with, or review by, a gynaecological oncologist or gynaecological oncology multidisciplinary team (MDT).

New Explanatory Note: TN.8.236 Radical Debulking with abdominal cavity involvement (Item 35721)

This procedure should be undertaken by a person with appropriate training in line with the National Framework for Gynaecological Cancer Control.

This item includes the extensive dissection and removal of the peritoneum from organs contained in the abdominal/pelvic cavity, including bowel, bladder, spleen, pancreas or liver.

This item does not include resection of bowel, bladder, spleen, pancreas or liver.

This item should not be used for staging procedures for gynaecological malignancy.

This item should not be used for a lymph node recurrence without involvement of peritoneal surfaces.

New Explanatory Note: TN.8.237 Excision of benign vaginal tumours (Item 35557)

This item should not to be used for the sole purpose of vaginal biopsy, drainage or Gartner duct cysts, cautery of granulation tissue, or removal of vaginal polyps.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

New Explanatory Note: TN.8.238 Partial Vaginectomy (Item 35560)

This item not to be used for vaginal biopsy or polypectomy.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

New Explanatory Note: TN.8.239 Radical Vulvectomy (Item 35548)

Co-claiming with a relevant flap procedure is permitted. However, deep tissue mobilisation is included in this item.

Amended Explanatory Note: TN.8.2 Multiple Operations Rule (Items 13241, 35591, 35592, 35609, 35610, 35631, 35632, 35668, 35669, 35671, 35721, 35724, 35751)

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion ~~(except as provided in paragraph T8.2.3)~~ are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee

plus 50% for the item with the next greatest Schedule fee

plus 25% for each other item.

**Note:**

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.



- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
- (c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.
- (d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined above would apply in respect of the services performed by each medical practitioner.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see ~~note paragraph~~ TN.8.42, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

#### Extended Medicare Safety Net Cap

The Extended Medicare Safety Net (EMSN) benefit cap for items subject to the multiple operations rule, where all items in that claim are subject to a cap are calculated from the abated (reduced) schedule fee.

For example, if an item has a Schedule fee of \$100 and an EMSN benefit cap equal to 80 per cent of the schedule fee, the calculated EMSN benefit cap would be \$80. However, if the schedule fee for the item is reduced by 50 per cent in accordance with the multiple operations rule provisions, and all items in that claim carry a cap, the calculated EMSN benefit cap for the item is \$40 (50% of \$100\*80%).