Changes to excision procedure MBS services - Reference Guide

Date of change: 1 July 2021

Amended items: 30676* 30055

*Amendment to explanatory note or introduction of new explanatory note

Revised structure

- **6 July 2021 update: this factsheet now includes the final item descriptors and fees (inclusive of 1 July 2021 indexation) for the amended items listed above. There were no changes to the item descriptors for these items during the drafting of the legislation.**
- From 1 July 2021, Medicare Benefits Schedule (MBS) items for general surgery services are changing to reflect contemporary practice. These changes are a result of MBS Review Taskforce (Taskforce) recommendations and consultation with stakeholders.
- There will be changes to MBS services pertaining to general surgery categories: Laparoscopy and Laparotomy; Small Bowel Resection; Abdominal Wall Hernias; Oesophageal; Stomach; Liver; Biliary; Pancreas; Spleen; Oncology; Lymph Nodes; Excisions; and Bariatric.
- These changes are relevant for surgeons involved in the performance and claiming of eligible general surgery services; consumers claiming these services; private health insurers; and private hospitals.
- From 1 July 2021, billing practices will need to be adjusted to reflect these changes.

Patient impacts

Patients will receive Medicare rebates for general surgery services that are clinically appropriate and reflect modern clinical practice. Additionally, patients should no longer receive different Medicare rebates for the same operations as there should be less variation in the items claimed by different providers. In some cases, the changes will help doctors refer patients for the most suitable test/procedure for them.

Restrictions or requirements

Providers will need to familiarise themselves with the changes to the general surgery MBS items, and any associated rules and/or explanatory notes. Providers have a responsibility to ensure that any services they bill to Medicare fully meet the eligibility requirements outlined in the legislation.

Excision procedure MBS services changes

Amended item 30676* Excision of pilonidal sinus or cyst, or sacral sinus or cyst

Overview: Reference to 'definitive' excision which better describes the procedure.

Item Descriptor: Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (Anaes.)

MBS fee: $394.40

PHI Classification: A – Surgical patient **Clinical Category:** Skin

Amended item 30055 Dressing of wounds under general, regional or intravenous sedation

Overview: Providing flexibility to use the most appropriate sedation for the patient.

Item Descriptor: Wounds, dressing of, under general, regional or intravenous sedation, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.)

MBS fee: $76.95

PHI Classification: Type B - Non-band specific Type B day procedures
Clinical Category: Skin

Explanatory NoteTN.8.# Excision of pilonidal sinus - (item 30676)

Overview: Introducing a new explanatory note to state that where a flap is required in conjuction with item 30676, item 45203 can be claimed for this purpose.

Explanatory note text:
Where a fasciocutaneous flap is required to close the pilonidal sinus excision defect item 45203 (single stage local flap to repair defect) can be co-claimed with item 30676.

Australian Government
Department of Health

Where can I find more information?

For questions relating to implementation, or to the interpretation of the changes to general surgery MBS items prior to 1 July 2021, please email 1july2021MBSchanges.generalsurgery@health.gov.au. Questions regarding the proposed Proposed PHI Classifications should be directed to PHI@health.gov.au.

If you have a query relating exclusively to interpretation of the Schedule after the changes to the general surgery items have been implemented on 1 July 2021, please email askMBS@health.gov.au.

> *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.*