Changes to MBS Cardiac Surgical Services:

Other Cardiac Surgery Items including items related to Implanted Cardiac Devices (pacemakers, defibrillators, ECG loop recorders & cardiac resynchronisation devices)

Date of change: 1 July 2021

Legislation: Health Insurance Legislation Amendment (2021 Measures No. 1) Regulations 2021

Amended Items:

11720 11721 11727 13400 38212 38213 38285 38286 38365 38368 38508 38509 38512 38515 38518 38603 38609 38612 38615 38618 38621 38624 38627 38643 38653 38656 38670 38673 38677 38680 38700 38703 38706 38709 38715 38718 38721 38724 38727 38730 38733 38736 38739 38742 38745 38748 38751 38754 38757 38760 38766 55118 55130 55135

New Items:

38467 38471 38472 38474 38764

Deleted Items:

11715 11718 38371 38384 38387 38390 38393 38470 38473 38506 38507 38588 38613 38640 38647 38650 38654 38763

Items with No Change: 11719 11724 11725 11726 38600

Revised structure

From 1 July 2021, Medicare Benefits Schedule (MBS) items for cardiac procedural services are changing to reflect contemporary practice. These changes are the result of MBS Review Taskforce (the Taskforce) recommendations following extensive consultation with stakeholders.

A number of procedural items are amended to clarify what items are not appropriate to claim at the same time with the procedure, because they are considered inherent to the primary procedure. Examples include insertion of intercostal drains and intercostal nerve blocks to procedures crossing the thorax.

Item descriptors have been updated to better reflect contemporary best practice, providing as much detail as reasonably possible to clarify eligibility of patients for the service and when electrophysiological testing is included in the service.

Where items are not performed as standalone procedures these have been incorporated into the appropriate items to create complete medical services and the old item deleted. An example of this is the item for cannulation of the coronary sinus (38588), this item will be deleted and has been incorporated into items where cannulation of the coronary sinus is required such as the valve replacement and repair items and aortic arch procedures.

From 1 July 2021, billing practices will need to be adjusted to reflect these changes.

Patient impacts

The creation of complete medical services aims to simplify the MBS and reduce rebate variability for patients. Patients should no longer receive different Medicare rebates for the same operation, as there should be less variation in the items claimed by different providers.

Patients will receive Medicare rebates for cardiac procedural services that are clinically appropriate and reflect modern clinical practice. These changes will provide access for patients to high-value cardiac investigations and procedures, leading to improved health outcomes.

Restrictions or requirements

Providers will need to familiarise themselves with the changes to the cardiac services 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.

Requested Service: An item with the symbol (R) refers to an R-type diagnostic imaging service. Medicare benefits for R-type (requested) ultrasound services in the MBS are only payable if the rendering practitioner receives a relevant request from an eligible requesting practitioner prior to the service being provided. Requesting practitioners must ensure that the service or services being requested are clinically relevant and necessary.

Same-Day Claiming Restriction:

“Not being a service associated with” refers to a restriction preventing the payment of a benefit when the service is performed in association, on the same occasion, with a specific MBS item or item range; another MBS item within the same group or subgroup or a similar type of service or procedure.

Claiming subsequent attendance items with items in Group T8 (items 30001 to 51171 of the MBS):

Some subsequent attendance items can’t be billed on the same day with any Group T8 item equal to or greater than $309.35 (These items include: 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009, 6011, 6013, 6015, 6019, 6052, or 16404).

Specialist subsequent attendance items (111 or CP item 117 and 120) can only be claimed on the same day as a surgical operation in Group T8 with a schedule fee of equal to or greater than $309.35 if the procedure is urgent and not able to be predicted prior to the commencement of the attendance. Item 115 allows for co-claiming of a consultation item, if the nature of the consultation could not be predicted prior to the Group T8 procedure with a MBS Fee higher than $309.35. It is expected that these items would be rarely required. Clinician records should clearly indicate the reasons why either the consultation or procedure is necessary including the clinical risk for the patient to defer.

Aftercare – post-operative care and treatment provided to patients after an operation:

Aftercare is the post-operative care and treatment provided to patients after a surgical operation or procedure.This includes all attendances until recovery and the final check or examination. Aftercare services can take place at a hospital, private rooms or a patient's home. MBS fees for most surgical items in MBS Group T8 include an aftercare component.

Some MBS services don't include aftercare and this is noted in their description. Group T8 items not containing this note include aftercare. Schedule fees for most surgical items include normal post-operative care. This means you can't bill attendance items for normal aftercare. However, if the MBS description of the surgical item performed excludes aftercare in the item's description, an attendance item can be billed for providing aftercare.

Multiple Operation Rule (MOR) – applies when 2 or more MBS items from Category 3, Group T8 for services performed on a patient on one occasion:

The total schedule for all surgical items is calculated by applying the MOR. That is:

- 100% of the fee for the item with the highest schedule fee

plus 50% of the fee for the item with the next highest schedule fee

plus 25% of the fee for any further surgical items

- Applying this rule results in one total schedule fee for all surgical items billed.

(see explanatory note *TN.8.2* at MBS Online for more information)

Thoracotomy/Sternotomy

Deleted item 38640 – Re-operation via sternotomy

This item is deleted, as the 3 time-based thoracotomy items (38640, 38643 and 38647) will be consolidated into a new single item, item 38643.

Deleted item 38647 – Thoracotomy or sternotomy

This item is deleted, as the 3 time-based thoracotomy items (38640, 38643 and 38647) will be consolidated into a new single item, item 38643.

Amended item 38643 – Re-operation via thoracotomy or sternotomy

Overview: This item has been amended following the consolidation of the three-time based thoracotomy items (38640, 38643 and 38647) into a single item.

Service/Descriptor: Re-operation via thoracotomy or sternotomy, by any procedure:

(a) including any division of adhesions if the time taken to divide the adhesions exceeds 30 minutes; and

(b) other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,567.65 (previously $1,100.75 – the new fee is based on a weighted average across all the consolidated items)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Lung and chest

Procedure Type: Type A – Advanced Surgical

Amended item 38656 – Thoracotomy or median sternotomy for post operative bleeding

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Thoracotomy or median sternotomy for post-operative bleeding, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $997.25

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Lung and chest

Procedure Type: Type A – Advanced Surgical

Circulatory Support

Deleted item 38588 – Cannulation of the coronary sinus

This item is not a standalone procedure, this item is being deleted as this procedure will be incorporated into appropriate items where cannulation of the coronary sinus is required to create complete medical procedures and only one item has to be claimed.

Deleted item 38613 – Intra-aortic balloon pump

This item is being deleted due to very low service volumes, but item 38612 remains to ensure there are no access issues to this procedure.

Amended item 38603 – Peripheral cannulation for cardiopulmonary bypass excluding post operative management

Overview: This item is amended to restrict co-claiming of this service to 'only with' items 38572 (operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta) and 38555 (simple replacement or repair of the aortic arch) as circulatory support is already included in these items.

Service/Descriptor: Peripheral cannulation for cardiopulmonary bypass, excluding post-operative management, other than a service:

(a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or

(b) associated with a service to which item 38555 or 38572 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 38555 or 38572

MBS fee: $997.25

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38609 – Insertion of intra-aortic balloon pump, by arteriotomy

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.).

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $498.55

Benefit: 75% only

Private Health Insurance Classifications*:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Surgical

Amended item 38612 – Removal of intra aortic balloon pump, with closure of artery by direct suture

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Removal of intra aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $558.90

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Surgical

Amended item 38627 – Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation,

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38627, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $696.70

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Surgical

Transoesophageal examination

Amended item 55118 – Heart, two dimensional or three-dimensional real time transoesophageal examination

Overview: Removal of the reference to "video tape" as this is not relevant to contemporary practice, where recordings are digital and inclusion of “three- dimensional” to reflect contemporary practice.

Service/Descriptor: Heart, two dimensional or three-dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level, if:

(a) the service includes:

(i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and

(ii) recordings on digital media; and

(b) the service is not an intra operative service; and

(c) not being a service associated with a service to which an item in Subgroup 3 applies

(R) (Anaes.)

Explanatory Note: Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Billing requirement: Not claimable with an item in Subgroup 3

MBS fee: $282.15

Benefit: 75% and 85%

Private Health Insurance Classifications:

Clinical Category: Support List

Procedure Type: Type B - Band 1

Amended item 55130 – Intra-operative two-dimensional or three-dimensional real time transoesophageal echocardiography

Overview: Removal of the reference to "video tape" as this is not relevant to contemporary practice, where recordings are digital. The amendment also clarifies that this service cannot be provided in association with an item in Subgroup 3.

Service/Descriptor: Intraoperative two dimensional or three-dimensional real time transoesophageal echocardiography, if the service:

(a) includes Doppler techniques with colour flow mapping and recordings on digital media; and

(b) is performed during cardiac surgery; and

(c) incorporates sequential assessment of cardiac function before and after the surgical procedure; and

(d) is not associated with a service to which item 55135, or an item in Subgroup 3, applies

(R) (Anaes.)

Billing requirement: Not claimable with item 55135 or an item in Subgroup 3

MBS fee: $174.10

Benefit: 75% or 85%

Private Health Insurance Classifications:

Clinical Category: Support List

Procedure Type: Unlisted

Amended item 55135 – Intra-operative two-dimensional or three-dimensional real time transoesophageal echocardiography

Overview: Removal of the reference to "video tape" as this is not relevant to contemporary practice, where recordings are digital. This item is only claimable in conjunction with surgical valve items and has been updated to reflect the new valve items following a restructure of these items. This item is only claimable with items 38477 (valve annuloplasty with insertion of ring), 38484 (aortic or pulmonary valve replacement), 38499 (mitral or tricuspid valve replacement), 38516 (simple valve repair) and 38517 (complex valve repair).

Service/Descriptor: Intraoperative two dimensional or three-dimensional real time transoesophageal echocardiography, if the service:

(a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and

(b) includes Doppler techniques with colour flow mapping and recordings on digital media; and

(c) is performed during cardiac valve surgery (replacement or repair); and

(d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and

(e) is not associated with a service to which item 55130, or an item in Subgroup 3, applies

(R) (Anaes.)

Billing requirement: Claimable in conjunction with surgical valve items (38477, 38484, 38499, 38516 or 38517) Not claimable with item 55135 or an item in Subgroup 3

MBS fee: $362.15

Benefit: 75% and 85%

Private Health Insurance Classifications:

Proposed Clinical Category: Support List

Proposed Procedure Type: Unlisted

Ablation and division of pathways items

Amended item 38512 – Division of accessory pathway, isolation procedure,

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,183.55

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38515 – Division of accessory pathway, isolation procedure,

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,780.20

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38518 – Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,984.25

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Cardiac Tumours

Amended item 38670 – Cardiac tumour, excision of, involving the wall of the atrium or inter atrial septum,

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Cardiac tumour, excision of, involving the wall of the atrium or inter atrial septum, without patch or conduit reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies.

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,986.55

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category:	Heart and Vascular System
Procedure Type:	Type A – Advanced Surgical

Amended item 38673 – Cardiac tumour, excision of, involving the wall of the atrium or inter atrial septum,

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Cardiac tumour, excision of, involving the wall of the atrium or inter atrial septum, requiring reconstruction with patch or conduit, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,235.95

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38677 – Cardiac tumour arising from ventricular myocardium, partial thickness excision of

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Cardiac tumour arising from ventricular myocardium, partial thickness excision of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,091.80

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38680 – Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction

Overview: This item is amended to include same day claiming restrictions which have been introduced to clarify services that are considered not appropriate to be claimed in conjunction with this item.

Service/Descriptor: Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,481.20

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Ventricular Assist Devices

Amended item 38615 – Insertion of a left or right ventricular assist device

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Insertion of a left or right ventricular assist device, for use as:

(a) a bridge to cardiac transplantation in patients with refractory heart failure who are:

(i) currently on a heart transplant waiting list; or

(ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or

(b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or

(c) cardio respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks;

other than a service associated with a service to which:

(d) item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies; or

(e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,594.05

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38618 – Insertion of a left and right ventricular assist device,

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Insertion of a left and right ventricular assist device, for use as:

(a) a bridge to cardiac transplantation in patients with refractory heart failure who are:

(i) currently on a heart transplant waiting list; or

(ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or

(b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or

(c) cardio respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks;

other than a service associated with a service to which:

(d) item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies; or

(e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,986.95

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38621 – Left or right ventricular assist device, removal of,

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Left or right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38627, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $793.25

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A –Surgical

Amended item 38624 – Left or right ventricular assist device, removal of,

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Left and right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38627, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $891.35

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Intrathoracic Vessels Items

Amended item 38727 – Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass,

Overview: Amend this item to change co-claiming restrictions, as this item is not to be claimed as part of another procedure, this item provides for when this service is performed as a primary procedure.

Service/Descriptor: Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 38806 or 45503

MBS fee: $1,556.45

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38730 – Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass,

Overview: This item has been amended to include cardioplegia into the fee structure. As this item is be claimed as a primary procedure, claiming restrictions have been added to clarify appropriate billing.

Service/Descriptor: Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

New item 38474 – Repair, augmentation or replacement of branch pulmonary arteries – left or right (or both) with cardiopulmonary bypass

Overview: New item for the repair or replacement of branch pulmonary arteries for congenital heart disease, this is a complex paediatric surgery which is currently not well described by existing items.

Service/Descriptor: Repair, augmentation or replacement of branch pulmonary arteries—left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,257.10

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Congenital Heart Disease (aortic repair)

Amended item 38706 – Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,896.20

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38709 – Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,235.45 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Congenital Heart Disease (atrial septum)

Amended item 38739 – Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease.

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2036.55 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38742 – Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease

Overview: This item has been amended to include clinical indications to clarify when it is appropriate to claim this procedure and to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Explanatory Note: This item may be claimed without evidence of right heart overload in highly rare paediatric conditions.

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2002.05

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Congenital Heart Disease (ventricular septum)

Amended item 38748 – Ventricular septectomy, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Ventricular septectomy, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38751 – Ventricular septal defect, closure by direct suture or patch

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Ventricular septal defect, closure by direct suture or patch, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Baffles

Amended item 38745 – Intra-atrial baffle, insertion of, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Intra-atrial baffle, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38754 – Intraventricular baffle or conduit, insertion of, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Intraventricular baffle or conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,780.20

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Patent ductus arteriosus

Amended item 38700 – Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,110.65

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38703 – Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardioplumonary bypass, for congenital heart disease

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2008.85 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Main pulmonary artery

Amended item 38715 – Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease.

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure.

Service/Descriptor: Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,775.45

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38718 – Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass,

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,245.70 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Vena Cava

Amended item 38721 – Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease.

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure.

Service/Descriptor: Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,556.45

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38724 – Vena cava, anastomosis or repair of, with cardiopulmonary bypass,

Overview: Amend this item to clarify what items are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,264.55 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Ventricular Surgery

Deleted item 38506 – Left ventricular aneurysm, plication of

The three items (38506, 38507 & 38508) for left ventricular aneurysm repair items have been consolidated to create a single item under item 38508

Deleted item 38507 – Left ventricular aneurysm resection with primary repair

The three items (38506, 38507 & 38508) for left ventricular aneurysm repair items have been consolidated to create a single item under item 38508

Amended item 38508 – Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs

Overview: Amended item which is a consolidation of the three left ventricular aneurysm repair items. The new item also incorporates changing techniques, which have developed due to shifts in cardiac pathologies over time, noting a patch reconstruction is generally the best-practice approach.

Service/Descriptor: Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,996.20 (previously $2,463.30)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38509 – Repair of ischaemic ventricular septal rupture

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure.

Service/Descriptor: Repair of ischaemic ventricular septal rupture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,485.45

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Pulmonary Shunts

Amended item 38733 – Systemic pulmonary or cavo pulmonary shunt, creation of, without cardiopulmonary bypass,

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure**.**

Service/Descriptor: Systemic pulmonary or cavo pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $1,556.45

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38736 – Systemic pulmonary or cavo pulmonary shunt, creation of, with cardiopulmonary bypass

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Systemic pulmonary or cavo pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Extracardiac Conduit

Amended item 38757 – Extracardiac conduit, insertion of, for congenital heart disease

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure.

Service/Descriptor: Extracardiac conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38760 – Extracardiac conduit, replacement of, for congenital heart disease

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure.

Service/Descriptor: Extracardiac conduit, replacement of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Miscellaneous Surgical Items including items related to Implanted Cardiac Devices – pacemakers, defibrillators, ECG loop recorders & cardiac resynchronisation devices

Deleted item 11715 – Blood dye dilution indicator test

This item is obsolete and no longer relevant to contemporary practice, as the devices are no longer in use.

Deleted item 11718 – Implanted pacemaker testing

This item is obsolete and no longer relevant to contemporary practice, as the devices are no longer in use.

Deleted item 38371 – Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient

This item has been made redundant following changes to items 38365 and 38368

Deleted item 38384 – AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in:

This item is being consolidated with item 38390 and will be now be claimed under new item 38471

Deleted item 38387 – AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in:

This item is being consolidated with item 38393 and will be now be claimed under new item 38472

Deleted item 38390 – AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for

This item is being consolidated with item 38384 and will be now be claimed under new item 38471

Deleted item 38393 – AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias.

This item is being consolidated with item 38387 and will be now be claimed under new item 38472

Deleted Item 38470 - Permanent Myocardial Electrode, insertion of, by thoracotomy or sternotomy

This item is being deleted as it is being consolidated with items 38473 & 38654 into a single new item 38467

Deleted Item 38473 – Permanent Pacemaker Electrode, insertion by open surgical approach

This item is being deleted as it is being consolidated with items 38470 & 38654 into a single new item 38467

Deleted item 38654 – Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy

This item is being deleted as it is being consolidated with items 38470 & 38473 into a single new item 38467

Deleted item 38650 – Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy

This item is deleted as it is being consolidated with item 38763 into a single new item 38764 for the surgical management of obstructive cardiomyopathy.

Deleted item 38763 – Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease

This item is deleted as it is being consolidated with item 38650 into a new item 38764 for the surgical management of obstructive cardiomyopathy.

Amended item 11720 – Implanted pacemaker testing, with patient attendance, following detection of abnormality by remote monitoring

Overview: This item is being amended to remove reference to MBS item 11718 - as this item is being deleted.

Proposed Service/Descriptor: Implanted pacemaker testing, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11721 applies.

Billing requirement: Not claimable with item 11721.

MBS fee: $69.50

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Support List

Procedure Type: Type C

Amended item 11721 – Implanted pacemaker testing of atrioventricular sequential, rate responsive, or antitachycardiac pacemakers

Overview: This item has been amended to include the requirement for a medical practitioner being immediately available to attend the patient and include same day claiming restriction with items 11704, 11719, 11720, 11725 or 11726. The amendment also removes the reference to deleted item 11718.

Proposed Service/Descriptor: Implanted pacemaker testing of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, other than a service associated with a service to which item 11704, 11719, 11720, 11725 or 11726 applies.

Performed where a medical practitioner is immediately available to attend the patient and where such testing is clinically indicated.

Explanatory Note: Performed where a medical practitioner is immediately available to attend the patient and where such testing is clinically indicated.

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Billing requirement: Not claimable on the same day with items 11704, 11719, 11720, 11725 or 11726, and a medical practitioner must be immediately available to attend to the patient if clinically required.

MBS fee: $72.55

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Support List

Procedure Type: Type C

Amended item 11727 – Implanted defibrillator testing, involving electrocardiography

Overview: Amended to remove reference to deleted item 11718.

Service/Descriptor: Implanted defibrillator testing involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, other than a service associated with a service to which item 11719, 11720, 11721, 11725 or 11726 applies.

Explanatory Note: Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Billing requirement: Not claimable on the same day with items 11719, 11720, 11721, 11725 or 11726.

MBS fee: $98.6

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Support List

Procedure Type: Type C

Amended item 38285 – Insertion of implantable ECG loop recorder, by a specialist or consultant physician for the diagnosis of a primary disorder

Overview: This item is to be amended to align with the improvements in technology which allow subcutaneous insertion of the device and as a result a patient may not require admission to a hospital. The requirement of "as an admitted patient in an approved hospital" has been removed. The anaesthetic approval will remain, as paediatric patients may also have these devices inserted and may require a general anaesthetic. The MBS fee has been amended to reflect the reduction in complexity and length of the procedure.

Note: Private health insurers are required to pay benefits for products listed on the Prostheses List, if the product is provided to the patient with the appropriate level of cover, as part of hospital or hospital substitute treatment. If this implantable recorder is inserted in an outpatient setting (e.g. provider's private rooms) setting the private insurer may opt to cover the cost of the device, but is not required to do so. It is important that providers obtain informed financial consent from patients prior to providing the service, including any out-of-pocket costs.

Service/Descriptor: Insertion of implantable ECG loop recorder, by a specialist or consultant physician, for the diagnosis of a primary disorder, including initial programming and testing, if:

(a) the patient has recurrent unexplained syncope and does not have a structural heart defect associated with a high risk of sudden cardiac death; and

(b) a diagnosis has not been achieved through all other available cardiac investigations; and

(c) a neurogenic cause is not suspected

(Anaes.)

Explanatory Note: The service to which item 38285 applies may be claimed for the insertion of an internal loop recorder (ILR) in the hospital setting as an admitted patient or as an outpatient. Private health insurers are required to pay benefits for products listed on the Prostheses List, if the product is provided to the patient with the appropriate level of cover, as part of hospital or hospital substitute treatment. When the ILR implant is inserted in the outpatient setting the private insurer may opt to cover the cost of the device, but is not required to do so.

Billing requirement: This item is a Group T8 item and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $160.55 (previously $198.95)

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type B - Non-band specific

Amended item 38286 – Removal of implantable ECG loop recorder

Overview: This item has been amended to remove the requirement of "as an admitted patient in an approved hospital". With the advancement of technology and subcutaneous insertion of these devices their removal no longer requires a hospital admission. The MBS fee has also been amended to reflect the shorter procedure time. This item will be claimable for the removal of the implanted loop recorder for in-hospital and out-of-hospital.

Service/Descriptor: Removal of implantable ECG loop recorder (Anaes.)

Explanatory Note: The service to which item 38286 applies may be claimed for the removal of an internal loop recorder (ILR) in the hospital setting as an admitted patient or as an outpatient.

Billing requirement: This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $144.60 (previously $179.20).

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type B – Non-band specific

Amended item 38365 – Insertion, removal or replacement of permanent cardiac synchronisation device,

Overview: This item is amended to include an assistant (due to level of complexity of procedure), in addition the amendment removes "sinus rhythm" from the inclusion criteria.

Service/Descriptor: Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient:

(a) has all of the following:

(i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy);

(ii) left ventricular ejection fraction of less than 35%;

(iii) QRS duration of greater than or equal to 130 ms; or

(b) has all of the following:

(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy);

(ii) left ventricular ejection fraction of less than 35%;

(iii) QRS duration of greater than or equal to 150 ms;

other than a service associated with a service to which item 38212 applies (H) (Anaes.) (Assist.)

Billing requirement: Claimable in-hospital only. Not claimable with item 38212. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $265.80

Benefit: 75%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Surgical

Amended item 38368 – Insertion, removal or replacement of permanent transvenous left ventricular electrode,

Overview: This item is amended to include provision for an assistant, due to level of complexity of procedure, as identified by the inclusion of the word “Assist”. In addition, the item is amended to remove "sinus rhythm" from the inclusion criteria.

Service/Descriptor: Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient:

(a) has all of the following:

(i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy);

(ii) left ventricular ejection fraction of less than 35%;

(iii) QRS duration of greater than or equal to 130 ms; or

(b) has all of the following:

(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy);

(ii) left ventricular ejection fraction of less than 35%;

(iii) QRS duration of greater than or equal to 150 ms;

other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.)

Billing requirement: Claimable in-hospital only. Not claimable on the same day with items 35200, 38200 or 38212. An MBS benefit for surgical assistance is payable where surgical assistance is provided to the surgeon by a medical practitioner other than the surgeon, the anaethetist or assistant anaethetist. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $1274.20

Benefit: 75%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A- Advanced surgical

Amended item 38653 – Open heart surgery

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure. Cannulation of the coronary sinus (item 38588) will be deleted as this is not a standalone procedure and has been incorporated into this item to create a complete medical procedure, simplifying claiming to a single item. The fee has also been increased to reflect this change.

Service/Descriptor: Open heart surgery, other than a service:

(a) to which another item in this Group applies; or
(b) associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,090.50 (increase in fee to reflect inclusion of deleted item 38588)

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Amended item 38766 – Ventricular augmentation, right or left, for congenital heart disease

Overview: Amend this item to clarify items which are not appropriate to claim with this procedure.

Service/Descriptor: Ventricular augmentation, right or left, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

New item 38471 – Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads

Overview: This new item consolidates items 38384 and 38390 into a single item, with clarification of the indications for use. Items 38384 and 38390 will be deleted.

Service/Descriptor: Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads, if the patient has one of the following:

(a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease;

(b) documented high-risk genetic cardiac disease;

(c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy;

(d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy);

other than a service to which item 38212 applies (H) (Anaes.) (Assist)

Billing requirement: Claimable in-hospital only. Not claimable on the same day with item 38212. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $1,095.30 (unchanged fee from consolidated items 38384 & 38390)

Benefit: 75%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

New item 38467 – Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach

Overview: This new item is a consolidation of items 38470, 38473 & 38654 into a single item to include all approaches as a completed medical procedure. Items 38470, 38473 & 38654 will be deleted.

Service/Descriptor: Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)

Billing requirement: Claimable in-hospital only**.** Not claimable on the same day with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $997.25 (consolidation of fees with deleted item 38588 (cannulation of coronary sinus) incorporated into new fee)

Benefit: 75%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

New item 38472 – Insertion, replacement or removal of implantable defibrillator generator,

Overview: This new item is a consolidation of items 38387 and 38393 into a single item. Items 38387 and 38393 will be deleted.

Service/Descriptor: Insertion, replacement or removal of implantable defibrillator generator, if the patient has one of the following:

(a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease;

(b) documented high-risk genetic cardiac disease;

(c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy;

(d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy);

other than a service to which item 38212 applies (H) (Anaes.) (Assist)

Billing requirement: Claimable in-hospital only. Not claimable on the same day with item 38212. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $299.50 (unchanged fee from fee of consolidated items)

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Surgical

New item 38764 – Ventricular myectomy, for relief of right or left ventricular obstruction,

Overview: A new item created to consolidate items 38650 and 38763 for the surgical management of obstructive cardiomyopathy into a single item as a complete medical service.

Service/Descriptor: Ventricular myectomy, for relief of right or left ventricular obstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

(H) (Anaes.) (Assist.)

Billing requirement: Not claimable with items 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503

MBS fee: $2,221.00

Benefit: 75% only

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A – Advanced Surgical

Electrophysiological Studies

Amended item 38212 – Cardiac electrophysiological study involving 4 or more catheters

Overview: This item is amended to remove the indication of defibrillator testing - as this will be included in item 38213.

Service/Descriptor: Cardiac electrophysiological study involving 4 or more catheters for:

(a) supraventricular tachycardia investigation; or

(b) complex tachycardia inductions; or

(c) multiple catheter mapping; or

(d) acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or

(e) catheter ablation to intentionally induce complete atrioventricular block; or

(f) intraoperative mapping;

other than a service associated with a service to which item 38209 or 38213 applies (Anaes.)

Billing requirement: Not claimable on the same day with items 38209 or 38213. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $1,428.05

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A- Advanced Surgical

Amended item 38213 – Cardiac electrophysiological study

Overview: This item is amended to include the indication of defibrillator testing in the instances when this is still required.

Service/Descriptor: Cardiac electrophysiological study, performed either:

(a) during insertion of implantable defibrillator; or

(b) for defibrillation threshold testing at a different time to implantation;

other than a service associated with a service to which item 38209 or 38212 applies (Anaes.)

Billing requirement: Not claimable on the same day with items 38209 or 38212. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $425.30

Benefit: 75% & 85%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type A- Surgical

Cardioversion

Amended item 13400 – Restoration of cardiac rhythm by electrical stimulation (cardioversion)

Overview: This item has been amended to restrict its use to a hospital or hospital- equivalent setting, as indicated by the 'H' in the descriptor, to ensure best practice care, as performing outside a hospital could compromise patient safety.

Service/Descriptor: Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (H) (Anaes.)

Billing requirement: Claimable in-hospital only. This item is part of the Group T8 items and will be subject to the over-arching restrictions applied to T8 items.

MBS fee: $100.75

Benefit: 75%

Private Health Insurance Classifications:

Clinical Category: Heart and Vascular System

Procedure Type: Type B – Non-band specific

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS will be available on 1 July 2021 on the MBS Online website at MBS Online. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

For questions relating to implementation, or to the interpretation of the changes to cardiac surgical MBS items prior to 1 July 2021, please email cardiacservices@health.gov.au.

For questions regarding PHI classifications, please email PHI@health.gov.au.

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

Subscribe to 'News for Health Professionals' on the Department of Human Services 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 Department of Human Services website or contact the Department of Human Services on the Provider Enquiry Line – 13 21 50.

The data file for software vendors is expected to become available by early June 2021 and can be accessed via the MBS Online website under the Downloads page.

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