Changes to General MBS Items for Orthopaedic Surgery

Last updated: 1 July 2021

- From 1 July 2021, the MBS items for orthopaedic surgery will be changing to support high value care, reflect contemporary clinical practice, and improve quality of care and safety for patients. These changes are a result of the MBS Review Taskforce (the Taskforce) recommendations and extensive consultation with key stakeholders.
- These changes are relevant to specialists involved in the provision of orthopaedic surgery services, consumers claiming these services, private hospitals, and private health insurers.
- Billing practices from 1 July 2021 will need to be adjusted to reflect these changes.

Summary of the changes

From 1 July 2021, there will be a revised MBS item structure for orthopaedic surgery. The changes will affect general orthopaedic items and items specific to each subspecialty;

- For information relating to the sub-specialty specific changes to orthopaedic surgery services, please refer to the relevant factsheet on the MBS Online website. Factsheets are now available for the Foot and Ankle, Hand and Wrist, Shoulder and Elbow, Hip, Knee and Paediatric sub-specialties.
- Changes to general orthopaedic items, and changes that affect similar procedures across more than one sub-specialty, are provided below.

What are the key changes?

The new orthopaedic item structure will be included in the MBS under Subgroups 1 to 15 of Group T8 – Surgical Operations.

The MBS items have been restructured to create a more logical and streamlined group of items in line with contemporary practice.

Changes have been made to some item descriptors to create complete medical services. Descriptors now specify the components to be included in a procedure to provide greater clarity on the use of the items. A number of items have been amended to include a provision for surgical assistance to reflect the complexity of the procedures and support patient safety and outcomes.

Please note that the information provided is a general guide only and subject to revision. 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.

The following information provides an overview of key changes within the general orthopaedic surgery schedule.

Bone Grafting

Items 48200–48242, 47726, 47729, 47732 and 47951:

- Have been consolidated under 5 new items for bone grafting (48245, 48248, 48251, 48254 and 48257) which are based on the type of graft and the complexity of the procedure required to harvest the graft.
- The new items are intended to be used as graft-specific (secondary) item numbers that are co-claimed with procedure-specific primary items.
- Separating bone graft items from the primary procedure reflects the technical expertise required for harvesting and applying the graft, which can vary considerably.
- Please note that simple bone grafts and graft substitutes should not attract specific MBS rebates; where bone grafting is included within a primary procedure item, this is noted within the descriptor.
- The new items are intended to provide greater clarity and consistency for clinicians and patients.

Osteectomy

Items 48400, 48403, 48406, 48409, 46396, 48412, 48415, 48418, 48421, 48424, 48427 47501, 47504, 47507 and 47510:

- The term ‘osteectomy’ has been removed from all orthopaedic MBS items.
- ‘Osteectomy’ is a broad term that does not have precise clinical meaning; as a result it is unclear in which circumstances it is appropriate for clinicians to claim a separate item for bone procedures.
- Where it is appropriate to claim a separate item for osteectomy, new items have been created to prevent access gaps in the MBS.
- Please refer to the relevant sub-specialty fact sheet for further details.

Internal and External Fixation

Items 47924 and 47927:

- Have been amended to provide clarity around usage.
- This includes replacing the phrase ‘per bone’ with ‘per incision’.
- The phrase ‘and suture’ has been removed from item 47924 to account for multiple techniques for wound closure.

Items 47929, 47930 and 47948:

- Items 47930 and 47948 have been consolidated under item 47929 for removal of an internal or external fixation.
- The items allow for different surgical methods that result in the same clinical outcome.
- The item can be claimed ‘per incision’ and should occur as a hospital service in an operating theatre.

Tendon Procedures

Items 47957, 47963, 47966 and 47969:

- Have been replaced with items specific to each sub-specialty in an effort to provide rebates for high value care and guide appropriate co-claiming.
- Please refer to the relevant sub-specialty fact sheet for further details.

Item 47954:

- Has been amended to specify the clinical indication for the surgery by including the word ‘traumatic tear or rupture’.
- Changes to the item provide greater clarity regarding appropriate clinical use of the item and aim to guide appropriate co-claiming.

Joint Procedures

Items 50100, 50102, 50103, 50104, 50106, 50109 and 50127:

- Have been replaced with items specific to each sub-specialty in an effort to provide rebates for high value care and guide appropriate co-claiming.
- Please refer to the relevant sub-specialty fact sheet for further details.

Item 50115:

- Has been amended to specify that the item excludes joints of the spine on recommendation of the Spinal Surgery Clinical Committee.
- The service covered by item 50115 is already covered by other items within the spine sub-category.

Insertion of a Bone Growth Stimulator

Item 47920:

- Has been deleted as item has low clinical utility, there are safety concerns and overall lacks clinical evidence.

Diagnostic Biopsies

Items 50200 and 50201:

- Have been amended to reflect the difference between the two biopsy procedures, provide clarity and create complete medical services.
- Item 50200 is for core needle biopsy while item 50201 is for incisional biopsy.
- The term ‘deep’ has been removed from the descriptors because it is ambiguous and has no clinical meaning.
- Histological proof of the benign, the aggressive benign or the malignant nature of the tumour should be obtained.

Ganglion, Bursa and Cyst Procedures

Item 30111:

- Has been replaced with items specific to each sub-specialty in an effort to support high value care and guide appropriate co-claiming.
- Please refer to the relevant sub-specialty fact sheet for further details.

Item 30107:

- Has been amended to limit the scope of the item to the excision of ganglion.
- The phrase ‘or small bursa’ has been removed from the descriptor as it does not properly guide clinical use.
- Removal of the term will prevent a service shift to item 30107 following the removal of item 30111.

Item 47900:

- Has been amended to more clearly specify the items intended use.
- The item covers injection or aspiration of a unicameral bone cyst.
- The item should primarily be used for paediatric patients, as unicameral bone cysts are predominantly a childhood condition.

Osteomyelitis Procedures

Items 43503, 43506, 43509, 43512, 43515 43518 and 43524:

- Have been consolidated under three new items for the treatment of septic arthritis and osteomyelitis.
- New item 43527 covers the treatment of the sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or maxilla (other than alveolar margins).
- New item 43530 covers the treatment of the scapula, ulna, radius, tibia, fibula, humerus or femur.
- New item 43533 covers the treatment of the spin or pelvis.
- Removing the distinction between acute and chronic osteomyelitis makes it possible to consolidate services under fewer items and will simplify and modernise the MBS.

Mass Lesion Procedures

Item 47936:

- Has been consolidated under item 50426 given the ambiguity of the term ‘exostosis’ in the context of bone tumours.

Items 50203, 50206 and 50209:

- Have been amended to better reflect the approach to surgical resection and the complexity of the procedure.
- Item 50203 provides for excision of a bone or soft tissue tumour.
- Items 50206 and 50209 provide for the excision of a bone tumour and a combination of autograft, allograft and cementation.
- Histological proof of either the benign, the aggressive benign, or the malignant nature of the process should be obtained.

Items 50212, 50215, 50218, 50221 and 50224:

- Have been amended to better reflect the approach to surgical resection and to remove specific reference to the anatomical site.
- The updated items include all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).

Items 50227 and 50230:

- Have been consolidated under items 50206, 50209, 50215, 50218 and 50224.

Items 50233, 50236 and 50239:

- Have been amended to more clearly define the anatomical site of the amputation and to specify that the procedure is indicated for aggressive bone and soft tissue tumours.
- The item includes all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The changes have been made to these items to better reflect modern clinical practice.

Items 50242 and 50245:

- Have been created to provide new items for revision procedures associated with mass lesions.
- Item 50242 applies to endoprosthetic replacement previously undertaken for procedures covered by items 50218 or 50224.
- Item 50245 applies to enbloc resection previously undertaken for procedures covered under items 50215, 50218, 50224.
- The need to revise previous reconstructive procedures to treat malignant or aggressive bone tumours is increasing because an increasing number of limb-sparing procedures are performed and the survival rates for these patients are improving.
- The items will ensure there is no service gap on the MBS with regard to the revision of mass lesion procedures.

Pelvic Ring Fractures

Item 47486 and 47489:

- Have been amended to anatomical landmarks, the extent of injury and the surgical procedure used by clinicians better reflects modern clinical practice.
- The items are to be used to treat the anterior and posterior pelvic ring respectively.
- The items can only be used if there is a clinical indication for open reduction and internal fixation.

Acetabular Fractures

Items 47492 and 47495:

- Item 47492 has been consolidated under item 47495 for treatment of fracture of the acetabulum and any associated dislocation.
- Consolidating these items will simplify the MBS.

Item 47514:

- Has been created to provide a new item for acetabulum posterior wall fracture requiring open reduction and internal fixation of both acetabulum and femoral head.
- Previously, no specific item has been available for this service.

Item 47501:

- Has been amended to include the location of the fracture and better reflect modern clinical practice.
- The phrase ‘single column fracture’ has been replaced with ‘treatment of anterior or posterior column fracture’.

Items 47504, 47507, 47510 and 47511:

- Items 47504, 47507 and 47510 have been consolidated under the item 47511.
- The new item covers the treatment of combined column fractures, T-type fractures, transverse fractures, anterior column and posterior hemi-transverse fractures affecting the acetabulum.

Item 47513:

- Has been deleted as it is not an independent procedure and should form part of other fracture procedures, if required.

Why are the changes being made?

The MBS Review Taskforce (the Taskforce) found that changes to orthopaedic surgery were required to reduce ambiguity among item descriptors, and to ensure the schedule is structured logically and reflects modern clinical practice.

These changes are a result of a review by the Taskforce, which was informed by the Orthopaedics Clinical Committee and discussion with key stakeholders. More information about the Taskforce and associated Committees is available via the Medicare Benefits Schedule Review page, within the ‘for consumers’ tab.

In some instances, item descriptors may differ from the descriptors proposed by the Taskforce. This is a result of recommendations made by the Orthopaedic Surgery Implementation Liaison Group (OSILG). The OSILG comprised representatives of orthopaedic sub-specialty societies, the Australian Medical Association (AMA) and the private hospital and health insurance sectors. The OSILG provided advice on the implementation of the item changes, including identifying potential service gaps and preventing unintended consequences arising as an outcome of the review.

A copy of the final Taskforce Orthopaedic Review report is available on the Department of Health’s website at: www.health.gov.au/resources/publications/taskforce-final-report-orthopaedic-mbs-items

What does this mean for providers?

Providers will need to familiarise themselves with the descriptor changes in the orthopaedic schedule, 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?

Patients will continue to receive Medicare rebates for orthopaedic surgery services that are clinically appropriate and reflect modern clinical practice.

Who was consulted on the changes?

The MBS Review Orthopaedic Clinical Committee was established in September 2016 to provide expert clinical advice and make recommendations to the MBS Review Taskforce on Orthopaedic MBS services.

The MBS Review included a public consultation process which provided feefback from peak bodies, clinicial experts and consumers. Feedback from stakeholders was considered by the Taskforce prior to making its final recommendations to the Government.

How will the changes be monitored and reviewed?

Service use of amended MBS orthopaedic surgery items will be monitored and reviewed post implementation.

All orthopaedic hand 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.

Further information

The full item descriptor(s) and information on amended schedule fees are now available on the MBS Online website. You can also subscribe to future MBS updates by visiting MBS Online and clicking ‘Subscribe’.

Enquiries

For questions relating to implementation, or to the interpretation of the new orthopaedic surgery MBS items, please email 1july2021MBSchanges.orthopaedics@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 Services Australia on the Provider Enquiry Line – 13 21 50.

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 below, and does not account for MBS changes since that date.