Changes to MBS Items for Orthopaedic Hip Surgery

Last updated: 1 July 2021

- From 1 July 2021, the MBS items for orthopaedic hip 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 hip surgery services. Overall, the new structure includes:

- **25 new items.**
- **6 amended items for services considered as requiring change in order to improve clarity of services for patients and providers, and improve the MBS to better reflect contemporary clinical practice.**
- **14 superseded items where services have been consolidated into new or amended items.**

What are the key changes?

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

The hip MBS items have been restructured to create a more logical and streamlined group of items with fees reflecting the level of service involved 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. Additional revision and recurrence items have been created to reflect the increased complexity of these procedures.

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.

The amended schedule more clearly defines major and minor bone grafting for primary hip replacement items. This was done through reference to the need for internal fixation. The existing hip revision items have been replaced with 16 new items that reflect the range of complexity associated with hip revision replacements, including the components replaced, the requirement for femoral osteotomy and the degree of bone grafting required.

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 hip surgery schedule.

General Hip Surgery

Item 49303:

- Has been amended to specify that the procedure is for open arthrotomy of the hip.
- This provides a more accurate and complete description of the surgery performed.

Hip Replacement (Primary)

Item 49309:

- Has been amended to remove reference to removal of a prosthesis.
- The item should be used for the removal of a native hip; it is not intended for the first stage of a two-stage revision procedure.

Items 49318 and 49319:

- Have been amended to reflect modern clinical practice and clarify that these items cannot be co-claimed with items from the bone graft section as bone grafting is considered a component of the services.
- The amended items no longer include the word ‘replacement’.

Item 49321:

- Has been amended to specify that the surgery can include bone graft, synthetic substitutes or metal augments, and clarifies that internal fixation is a mandatory part of the procedure.
- The changes reflect modern clinical practice and identify the circumstances in which it is appropriate for a patient to receive a complex primary hip replacement.
- Removing ‘major bone grafting’ from the item descriptor addresses ambiguity and variations in billing practices.

Hip Replacement (Revision)

Items 49312, 49324-49346, 49372-49398:

- Items 49312 and 49324-49346 have been replaced with 14 new items for hip revision (49372-49398).
- The new items better reflect modern clinical practice and the range of complexity associated with hip revision procedures.
- The items are differentiated by surgical complexity, with reference to the components replaced, the requirement for femoral osteotomy and the degree of bone grafting required.
- The new items include major or minor bone grafting, defined using the Paprosky scale and cannot be co-claimed with the bone graft section.

Fractures

Items 47522 and 49315:

- Item 47522 has been consolidated with item 49315 as it is not an independent procedure and should form part of other hip procedures.

Dislocations

Items 47048, 47047 and 47052:

- Item 47048 has been consolidated under two new items for closed reduction of a hip dislocation (47047 and 47052).
- The new items distinguish between the treatment of native and prosthetic hips.

Items 47051, 47049 and 47053:

- Item 47051 has been consolidated under two new items for open reduction of a hip dislocation (47049 and 47053).
- The new items distinguish between the treatment of native and prosthetic hips.
- The amendment reflects the range of complexity involved in these procedures; the treatment of a native hip dislocation is more complex than treatment of a prosthetic dislocation because it involves longer follow-up and has a higher risk of potential complications.

Joint Procedures

Item 50121:

- Has been deleted because it no longer reflects clinical practice.
- New items (47964, 47955 and 47956) for the repair of tendons around the hip have been created to account for services that may have previously been claimed using this item.

Item 50107:

- Has been created to provide a new item stabilisation of a hip joint.
- The item should be claimed as an independent procedure and now specifies that at least one of the following is a mandatory component of the service: repair of capsule, labrum, capsulorraphy or repair of ligament.
- Internal fixation is an optional component of the procedure.
- This item is required to account for the recommended deletion of item 50106 (joint stabilisation item).

Tendon Procedures

Item 47964:

- Has been created to provide a new item for iliopsoas tenotomy.
- Tenotomy of the iliopsoas is currently reimbursed using general open tenotomy item 47963, which has been deleted.

Item 47955:

- Has been created to provide a new item for gluteal tendon repair.
- A new item is required as clinical evidence suggests that surgical intervention is superior to corticosteroid therapy and physical therapy and at present no specific item number is available for the service.

Item 47956:

- Has been created to provide a new item for repair of the proximal hamstring or rectus femoris tendon.
- Repair of the proximal hamstring or rectus femoris tendon has been reimbursed using general tendon repair item 47954.

New Osteotomy Items

Items 48423 and 48426:

- Have been created to provide new items for pelvic and femoral osteotomy in adult patients (based on items 48424 and 48427).
- The exclusion for femoroacetabular impingement under the existing items has not been included as this was relevant to osteectomy.

Arthroscopic hip surgery

Items 49360 and 49363:

- Have been amended to restrict the items with any other hip joint procedure.

Item 49366:

- Has been amended to better describe inherent components of the procedure that are included if performed.
- The item now includes any associated bony or soft tissue procedure.

Why are the changes being made?

The MBS Review Taskforce (the Taskforce) found that changes to orthopaedic hip 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 hip 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 feedback from peak bodies, clinical 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 hip 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.