Changes to MBS Items for Orthopaedic Knee Surgery

Last updated: 1 July 2021

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

- **19 new items that represent complete medical services**
- **27 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- **14 superseded items where services have been consolidated into new or amended items.**
- **1 deleted item where services have been assessed obsolete or no longer reflective of contemporary clinical practice.**

What are the key changes?

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

The knee 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. 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 existing knee arthroscopy items have been replaced with 9 new items, separated into three tiers based on complexity, which better reflect the range of complexity associated with arthroscopic procedures of the knee. This assists in simplifying the MBS and provides better guidance for providers billing arthroscopic procedures of the knee.

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 knee surgery schedule.

General Knee Surgery

Items 49503 and 49506:

- Have been amended to reflect to reflect modern clinical practice and clarify the components of the procedure.
- This includes replacing the terms ‘chondroplasty’ and ’osteoplasty’ with the phrase ‘repair or replacement of chondral or osteochondral surface’ and removal of the term ‘patellofemoral stabilisation’.
- Patellofemoral stabilisation procedures are covered under item 49564 and this component has therefore been removed from these items.

Item 49509:

- Has been amended to clarify that the service must be an open procedure, specify appropriate co-claiming with arthroplasty and to remove the term ‘arthrodesis’.
- In most patients with osteoarthritis who undergo arthroplasty, synovectomy is an inherent part of the procedure and should not be claimed separately.
- The amendments will guide the co-claiming of synovectomy in conjunction with arthroplasty without inflammatory arthropathy or post-infection or post-traumatic disorders.

Item 49515:

- Has been amended to reflect current clinical practice and clarify that the item should be used for the insertion of a spacer (rather than revision surgery items).

Items 49516 and 49517:

- Item 49517 has been split into two items for unicompartmental arthroplasty: one for unilateral unicompartmental arthroplasty (49517) and one for bilateral unicompartmental arthroplasty (49516).
- Reference to the anatomical site clarifies when this item can be used, such as preventing the use of this item if resurfacing devices are used rather than unicompartmental arthroplasty.

Item 49590:

- Has been created to provide a new item for open or arthroscopic excision of a ganglion, cyst or bursa around the knee.
- The item is an independent procedure and cannot be claimed with other surgical operations; in particular, the item cannot be claimed with additional arthroscopy items.
- Creating a specific item for around the knee prevents service gaps from appearing in the MBS and preserves patient access.

Knee Replacement (Primary)

Item 49518:

- Has been amended to clarify the item by indicating the complexity of the procedure through the use of revision components rather than bone grafting.
- The item includes revision of patellofemoral joint replacement to total knee replacement, patellar resurfacing, and bone grafting, if performed.

Item 49519:

- Has been amended to clarify the item by indicating the complexity of the procedure through the use of revision components rather than bone grafting.
- The item includes patella resurfacing and bone grafting, if performed.

Item 49521 and 49524:

- Have been amended to clarify the item by indicating the complexity of the procedure through the use of revision components rather than bone grafting.
- The service must involve the use of revision components to the femur or tibia.
- The items includes ligament reconstruction, patellar resurfacing, and bone grafting, if performed.

Knee Replacement (Revision)

Item 49527:

- Has been amended to clarify that the item should be used for minor revision procedures.
- The item includes exchange of polyethylene component (including uni), and/or insertion of patellar component.

Item 49530 and 49533:

- Have been amended to clarify that the item requires exchange of either femoral or tibial component and should not be used for revision of unicompartmental with unicompartmental implants.
- The item includes patellar resurfacing and bone grafting, if performed.

Item 49525:

- Has been created to provide a new item for revision of unicompartmental arthroplasty with unicompartmental components.
- The item accurately describe the complexity of the procedure through reference to the components being revised.

Item 49534:

- Has been amended to better reflect the item is intended for use in cases of failed non-operative treatment.
- The phrase ‘total replacement arthroplasty’ has been replaced with ‘replacement of patella and trochlea’.

Item 49554:

- Has been amended to specify that the item cannot be co-claimed with proposed bone graft items.
- The updated item modernises the MBS and describes a complete medical service.

Knee Repair and Reconstruction

Item 49536:

- Has been amended to clarify the components included in the procedure to better guide appropriate use.
- The term ‘reconstruction’ has been replaced with the phrase ‘for chronic instability’ to highlight that the item should be used for ligament repair.
- The item includes any associated intra-articular knee surgery.

Items 49539 and 49542:

- Item 49539 has been consolidated under item 49542 to provide an updated item for anterior or posterior cruciate ligaments reconstruction.
- The item includes graft harvest, donor site repair, meniscal repair, collateral ligament repair and associated intraarticular procedures.

Item 49544:

- Has been created to provide a new item for multi-ligament reconstruction.
- The updated item is a complete medical service and should not be co-claimed with other tendon or ligament transfer items.

Knee Arthrodesis

Items 49512 and 49545:

- Item 49545 has been consolidated under item 49512 for combined primary and revision arthrodesis in an effort to make the MBS more user friendly.
- Amendments reflect that the item covers arthrodesis by any method.

Knee Arthroscopy

- Items 49557, 49558, 49559, 49560, 49561, 49562 and 49563:
- Have been replaced with nine new items for knee arthroscopy, organised into three tiers of complexity (see below).
- Only a single arthroscopy item for each procedure may be utilised per knee.
- The item billed must be for the most complex procedure undertaken and must not be utilised in conjunction with any other knee arthroscopy item.
- *Tier one (item 49570):*
    - Covers basic diagnostic arthroscopy (where the diagnosis is uncertain).
- *Tier two (items 49572, 49574, 49576, 49578 and 49580)*
    - Covers medium complexity arthroscopy.
    - These include services for partial meniscetomy (for traumatic or a-traumatic meniscus tear), removal of loose bodies, treatment of chondral lesions and soft tissue release.
- *Tier three (items 49582, 49584 and 49586):*
    - Cover complex knee arthroscopy.
    - These include services for chondral, osteochondral and meniscal graft, meniscal repair and arthroscopic synovectomy.

An explanatory note has been created to guide appropriate claiming of these items. For patients with uncomplicated osteoarthritis it is expected that arthroscopy should only be performed in patients with surgeon-confirmed obstructive symptoms. Patient selection for knee arthroscopy in the presence of osteoarthritis should conform to the October 2016 Position Statement from the Australian Knee Society on Arthroscopic Surgery of the Knee.

Item 49564:

- Has been amended to specify the included elements of the procedure.
- This includes soft tissue reconstruction and tendon transfer; or tibial tuberosity transfer with bone graft and internal fixation.

Item 49565:

- Has been created to provide a new item for patella-femoral reconstruction.
- The new item accounts for the greater complexity of knee stabilisation procedures that require patellofemoral reconstruction.

Item 49566:

- Has been consolidated under item 48586 for arthroscopic synovectomy.
- Please see tier three of the knee arthroscopy section.
- Having a single location for all knee arthroscopy items will assist practitioners who bill these items

Fracture Items

Item 47549 and 47558:

- Have been amended to clarify that internal fixation and arthrotomy are part of the procedure and cannot be claimed separately.
- This will make it easier for clinicians to determine which items to use and provides greater clarity for consumers and clinicians.

Item 47559:

- Has been created to provide a new item for treatment of medial and/or lateral tibial plateau fractures.
- This reflects the increased complexity and time and resources required to apply an external fixator and creates a complete medical service.

Items 47561, 47564, 47567 and 46568:

- Items 47564 and 47567 have been consolidated under item 46568 for treatment of a fracture of the tibia by closed reduction.
- Separate items are not required for different methods of treatment; consolidating these items will simplify the MBS.
- Item 47561 has been retained to provide a specific item for cast immobilisation.

Item 47573:

- Has been amended to provide a more accurate and complete description of the service performed.
- The item applies to proximal or distal intra-articular fractures and should not be used for treatment of medial malleolus fracture to distal tibia.
- The item includes arthrotomy or arthroscopy at fracture site, washout of joint, removal of loose fragments or intervening soft tissue, and capsule repair, if performed.

Item 47576:

- Is no longer required because this service can be incorporated into tibial shaft items where appropriate, or treated as part of a consultation.

Item 47582:

- Has been amended to clarify that the item applies to proximal and distal fractures.
- Changes to the descriptor clarify the components that (if performed) are considered part of the procedure: open reduction, internal fixation, arthrotomy, removal of loose fragments, repair of the quadriceps tendon or patella tendon, and stabilisation of the patellofemoral joint.
- This confirms that the item is a complete medical service and provides greater clarity for consumers and clinicians.

Items 47592 and 47593:

- Have been created to provide two new items for acute traumatic chondral injury to distal femoral and/or proximal tibial articular surfaces.
- The items are required to reflect current clinical practice for treating acute chondral or osteochondral injury.
- At present, these procedures are not well described, which leads to inconsistent billing practices.

Dislocation Items

Item 47054:

- Has been amended to clarify that the procedure includes application of an external fixator.

Item 47060

- Has been amended to specify that surgical assistant is permitted given the complexity of the procedure.
- Open reduction for dislocation of the patella is rarely required and the severity of the condition may require an assistant.

Osteotomy and Osteectomy

Item 48418:

- Has been deleted following the removal of the term osteectomy from all items.
- The item is no longer required as fixation is required for this type of osteotomy procedure.

Item 48421:

- Has been amended to remove the reference to osteectomy and better define the anatomical site and purpose of the procedure.
- The changes aim to reduce inappropriate co-claiming and define tibial or femoral osteotomy solely as a procedure for correcting alignment or rotation of the limb.

Item 48422:

- Has been created to provide a new item for distal femoral osteotomy.
- This is required to account for the small and specific number of clinical instances which warrant an osteotomy.

Why are the changes being made?

The MBS Review Taskforce (the Taskforce) found that changes to orthopaedic knee 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 knee 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 knee 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.