Changes to MBS Items for Orthopaedic Shoulder and Elbow Surgery

Last updated: 1 July 2021

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

- **14 new items.**
- **11 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.**
- **13 superseded items where services have been consolidated into new or amended items.**

What are the key changes?

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

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

This includes removing the existing distinction between open and arthroscopic shoulder and elbow surgery, allowing clinician's greater control over the method of surgery they wish to perform.

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.

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 shoulder and elbow surgery schedule.

Coraco-acromial ligaments and subacromial space

- Taskforce Report recommendation 74 (consolidate existing items 48900, 48903 and 48951 into two new items) and Recommendation 75 (consolidate existing items 48906, 48909 and 48960 into two new items) are not proceeding to implementation at this stage, due to the subsequent Medical Services Advisory Committee (MSAC) review of subacromial decompression services.
- Items 48900, 48903 and 48951 and items 48906, 48909 and 48960 will remain on the MBS to prevent a service gap, pending the outcome of MSAC's review.
- Further information will be provided on the outcome of MSAC's review, once finalised.

New Item for Biceps Tenodesis

Item 48972:

- Has been created to provide a new item for biceps tenodesis.
- This item is required to account for the recommended deletion of item 47966 (general tendon and ligament transfer).

Arthroplasty and Arthrotomy

Item 48912:

- Has been deleted as this service has been incorporated into new items.
- The item is not an independent procedure and should form part of other shoulder procedures.

Item 49818:

- Has been amended to specify that the item is for 'anatomic or reverse' shoulder replacement, and that associated rotator cuff repair, biceps tenodesis and tuberosity osteotomy are all included, if performed.
- Changes to this item clarify what is considered an inherent part of the surgery.
- This makes it easier for clinicians to determine which items to use and will reduce variation in billing.

Item 48924:

- Has been amended to specify that bone grafting is a mandatory component of the surgery.
- The term ‘requiring’ is ambiguous and has been replaced with the term ‘with’.

Item 49115:

- Has been amended to specify that clinicians can claim either a ‘total’ or ‘hemi’ elbow arthroplasty in an effort to better reflect modern clinical practice.
- Hemi-arthroplasty of the elbow has become available due to changes in prosthetic design.

Item 49117

- Has been amended to specify that the item must include bone grafting.
- Replacing ‘requiring’ with the word ‘with’ removes ambiguity and clarifies the intended use of the service.

Joint Stabilisation

Items 48930, 48933, 48957 and 48958:

- Items 48930, 48933 and 48957 have been consolidated under item 48958 for treatment of anterior, posterior or multi-directional instability by open or arthroscopic means.
- Open and arthroscopic joint stabilisation are different surgical methods that result in the same clinical outcome; as a result the component items can be combined.

Items 49103, 49104 and 49105:

- Item 49103 has been split into two items for ligamentous stabilisation of the elbow.
- The new items specify that ligament repair is included in either method of surgery, but that tendon harvesting and graft are only included in chronic ligament repair.
- The amended descriptor reflects contemporary clinical practice and addresses a service gap by providing a MBS item number for acute traumatic injury of the elbow.

Synovectomy

Items 48936 and 48954:

- Item 48936 has been consolidated under item 48954 for synovectomy as an independent procedure.
- In keeping with other recommendations, the item does not specify the approach type (open or arthroscopic).

Arthrodesis

Item 48942:

- Has been amended to guide appropriate use with the bone grafting table.
- The changes recognise that bone grafting is an inherent part of the procedure and should not be claimed separately.

Arthroscopy

Item 49118:

- Has been amended to specify that clinicians can claim this item for the surgical treatment of epicondylitis.
- The amended descriptor reflects contemporary clinical practice and addresses a gap in the MBS by providing an item number for the surgical treatment of epicondylitis.

Replacement of Radial Head of the Elbow

Item 49112:

- Has been amended to remove reference to silastic implants.
- Silastic implants have been discontinued due to complications associated with implant fracture.

New Item for Excision of Olecranon Bursa

Item 49124:

- Has been created to provide a new item for excision of olecranon bursa.
- There is currently no specific MBS item for surgery to excise the olecranon bursa.

New Item for Biceps Brachii

Item 47953:

- Has been created to provide a new item for repair of a bicep brachii tendon.
- There is currently no specific MBS item for surgery to repair the biceps brachii tendon at the elbow.

Fractures

Item 47456

- Has been amended to include provisions for a surgical assistant.
- The closed reduction of a distal surgical fracture is a complex procedure that requires an assistant to ensure the proper union of healing bones.

Dislocations

Items 47006 and 47007:

- Item 47006 has been consolidated under the new item for acromioclavicular or sternoclavicular joint dislocation (47007).
- There is currently no appropriate MBS item for surgically managing an acromioclavicular or sternoclavicular joint dislocation, despite this being a well-established contemporary procedure.
- The new item is a complete medical service that allows clinicians to choose the method of surgery.

Osteotomy and Osteectomy

Items 48412 and 48415:

- Have been amended to remove the term osteectomy.
- This amendment will ensure the items are consistent with other items while reducing ambiguity and guide appropriate co-claiming.

Item 48980:

- Has been created to provide a new item for excision of heterotopic ossification.
- The item accounts for removal of the term osteectomy elsewhere in the schedule and will ensure providers can claim Medicare benefits for the service where it is clinically appropriate, specifically for heterotopic ossification, myositis ossificans or other dystrophic pathologies.

Why are the changes being made?

The MBS Review Taskforce (the Taskforce) found that changes to orthopaedic shoulder and elbow 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 shoulder and elbow 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 shoulder and elbow 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 prior to 1 July 2021, please email 1july2021MBSchanges.orthopaedics@health.gov.au.

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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.