

## **EXPLANATORY STATEMENT**

### *Health Insurance Act 1973*

#### *Health Insurance (General Medical Services Table) Regulations 2021*

Subsection 133(1) of the *Health Insurance Act 1973* (Act) provides that the Governor-General may make regulations, not inconsistent with the Act, prescribing all matters required or permitted by the Act to be prescribed, or necessary or convenient to be prescribed for carrying out or giving effect to the Act.

Part II of the Act provides for the payment of Medicare benefits for professional services rendered to eligible persons. Section 9 of the Act provides that Medicare benefits be calculated by reference to the fees for medical services set out in prescribed tables.

Subsection 4(1) of the Act provides that regulations may prescribe a table of general medical services which sets out items of general medical services, the fees applicable for each item, and rules for interpreting the table. The table made under this subsection is referred to as the general medical services table. The most recent version of the regulations is the *Health Insurance (General Medical Services Table) Regulations (No. 2) 2020*.

#### **Purpose**

The purpose of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) is to implement annual Medicare indexation and the Government's response to recommendations from the MBS Review Taskforce (the Taskforce) relating to general surgery and orthopaedic services.

The schedule fees of GP and specialist attendances, diagnostic investigations, and therapeutic and procedural items are increased by 0.9 per cent. This reflects the Government's policy regarding Medicare indexation and means that patients will receive an increased Medicare benefit for these services.

The Government's response to the Taskforce recommendations on general surgery will restructure the existing items to reflect contemporary practice, incentivise best clinical practice, combine like procedures, and clarify the requirements of ambiguous services to simplify the arrangements for doctors and patients. The changes will introduce 35 new items, amend 50 items and delete 73 items relating to laparoscopies and laparotomies, small bowel resections, abdominal wall hernia repairs, oncology and bariatric services, surgical excisions, and procedures relating to the oesophageal, stomach, liver, biliary, pancreas, spleen and lymph nodes.

The Government's response to the Taskforce recommendations on orthopaedic services will restructure the existing items to reflect contemporary practice, ensure services are clinically appropriate and improve quality of care and safety for patients. The changes will introduce 167 new items, amend 284 items and delete 143 items relating to orthopaedic services affecting the knee, hand and wrist, shoulder and elbow, hip, foot and ankle.

#### **Consultation**

In the 2017-18 Budget, the Government announced the re-commencement of indexation of Medicare benefits under the *Guaranteeing Medicare - Medicare Benefits Schedule - indexation* measure. The Regulations will continue the Government's policy regarding indexation by indexing the schedule fees of most general medical services.

No consultation was undertaken on the indexation component of this instrument as it continues the business-as-usual implementation of the Government's policy on Medicare indexation, which is expected by stakeholders to be applied on 1 July of each year. The complete list of all indexed schedule fees will be distributed to stakeholders through the Medicare Benefits Schedule (MBS) xml data file.

In the 2019-20 Mid-Year Economic and Fiscal Outlook (MYEFO), the Government announced its response to the Taskforce recommendations on general surgery under the *Guaranteeing Medicare — Medicare Benefits Schedule Review* measure. In the 2020-21 Budget, the Government announced its response to the Taskforce recommendations on orthopaedic services under the *Guaranteeing Medicare — Medicare Benefits Schedule review* measure.

The MBS Review is conducted by expert committees and working groups focusing on specific areas of the MBS. The clinical committee reports were released for public consultation to inform the final Taskforce reports and recommendations to Government. The general surgery and orthopaedic recommendations were informed through public consultation on the reports of the General Surgery Clinical Committee and the Orthopaedic Clinical Committee. Implementation Liaison Groups involving professional bodies and clinical experts have also been consulted to inform development of the Regulations.

Details of the Regulations are set out in the [Attachment](#).

The Regulations commence on 1 July 2021.

The Regulations are a legislative instrument for the purposes of the *Legislation Act 2003*.

Authority: Subsection 133(1) of the  
*Health Insurance Act 1973*

## **Details of the *Health Insurance (General Medical Services Table) Regulations 2021***

### Section 1 – Name

This section provides for the instrument to be referred to as the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

### Section 2 – Commencement

This section provides for the Regulations to commence on 1 July 2021.

### Section 3 – Authority

This section provides that the Regulations are made under the *Health Insurance Act 1973* (the Act).

### Section 4 – General medical services table

This section provides that Schedule 1 to the Regulations prescribes a table of medical services for the purpose of subsection 4(1) of the Act.

### Section 5 – Schedules

This section provides that each instrument that is specified in Schedule 2 to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms. Schedule 2 will repeal the *Health Insurance (General Medical Services Table) Regulations (No. 2) 2020*.

### Schedule 1 – General medical services table

This part of the Regulations remakes the existing general medical services table and applies the following policy changes:

#### **Indexation**

The Regulations apply annual indexation of most items in the general medical services table by prescribing a fee which has been increased by 0.9 per cent from the fee value listed in the current general medical services table.

Indexation will apply to approximately 4500 items including all services in Parts 3 to 7 and most attendance services in Part 2. Other medical practitioner items in groups A2, A19 and A23 will not be indexed to encourage medical practitioners to continue professional development.

#### **General surgery changes**

General surgery services are listed, amended and deleted to implement the Government's response to the MBS Review Taskforce (the Taskforce) recommendations. Services for laparoscopies and laparotomies, small bowel resections, abdominal wall hernia repairs, oncology and bariatric services, surgical excisions, and procedures relating to the oesophageal, stomach, liver, biliary, pancreas, spleen and lymph nodes are changed to reflect contemporary clinical practice.

The Taskforce report on general surgery can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce>. The general surgery Implementation Liaison Group provided advice to the Department on the implementation of the Taskforce recommendations. This advice resulted in minor changes to some recommendations to support the effective and practical implementation of the Government response to the Taskforce recommendations.

#### *Laparoscopy and laparotomy procedures*

Fourteen (14) laparoscopy and laparotomy items have been deleted and replaced with six (6) items to simplify the arrangements for doctors and patients:

- Items 30373, 30391 and 31450 are deleted and replaced with a new item (30721) for laparotomy or laparoscopy with division of adhesions (where the time taken for division of the adhesions takes more than 45 minutes but less than 2 hours), per recommendation 4 of the Taskforce report.
- Items 30375 and 30376 are deleted and replaced with a new item (30722) for laparotomy or laparoscopy, with division of adhesions if performed (and under 45 minutes), on a person 10 or more years of age for performing specified operations in the descriptor, per recommendation 5 of the Taskforce report.
- Items 30378, 30393 and 31452 are deleted and replaced with a new item (30724) for laparotomy or laparoscopy with division of adhesions (where the time taken for division of the adhesions takes more than 45 minutes but less than 2 hours), per recommendation 7 of the Taskforce report.
- Item 30379 is deleted and replaced with a new item (30725) for laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, per recommendation 8 of the Taskforce report.
- Items 30394, 30402 and 30575 are deleted and replaced with a new item (30723) for drainage of an intra-abdominal, pancreatic, or retroperitoneal collection or abscess by laparotomy, laparoscopy or extra-peritoneal approach, per recommendation 6 of the Taskforce report.
- Items 30571 and 30572 are deleted and replaced with a new item (30720) for appendectomy on a person 10 years of age or over, per recommendation 3 of the Taskforce report.

Twelve (12) laparoscopy and laparotomy items have been amended to clarify the item requirements or to reflect contemporary clinical practice:

- Items 30382 (recommendation 13), 30385 (recommendation 11), 30387 (recommendation 15), 30390 (recommendation 9), 30396 (recommendation 16), 30397 (recommendation 17), 30399 (recommendation 18), 30627 (amended for consistency with revised item 30390) and 31454 (recommendation 14) are amended to reflect current surgical best practice or to simplify the requirements of the item.
- Items 30574 (recommendation 19) and 30388 (recommendation 10) are amended and have a fee reduction as recommended by the Taskforce.
- Item 30384 (recommendation 12) is amended and has a fee increase to recognise the complexity of the procedure.

#### *Small bowel resection procedures*

Four (4) small bowel resection items have been deleted and replaced with two (2) new items to simplify the arrangements for doctors and patients

Items 30564 and 30566 are deleted and replaced with a new item (30730) for resection of small intestine including a small bowel diverticulum (such as Meckel's procedure) with anastomosis, or stricturoplasty, per recommendation 21 of the Taskforce report.

Items 30568 and 30569 are deleted and replaced with a new item (30731) for intraoperative enterotomy for visualisation of the small intestine by endoscopy (including endoscopic examination using a flexible endoscope), per recommendation 22 of the Taskforce report.

Item 30732 is a new item for peritonectomy surgery (duration greater than 5 hours) that provides a single benefit for the procedural components of the service, including hyperthermic intra-peritoneal chemotherapy, per recommendation 23 of the Taskforce report.

#### *Abdominal wall hernia procedures*

To simplify the abdominal wall hernia procedures, items 30609 and 30614 are deleted and replaced with a new item (30648) for the repair of femoral or inguinal hernia or infantile hydrocele on a person 10 years of age or over by open or minimally invasive approach. This was proposed by the Taskforce under recommendation 25.

Item 30657 is a new item for abdominal wall reconstruction with component separation, per recommendation 26 of the Taskforce. This item is intended to treat large abdominal wall defects that are a formidable surgical challenge that requires planning, expertise and peri and post-operative care in excess of the other ventral hernia repair items.

The hernia repair items have been restructured to grade the items by complexity in hernia repair. This was proposed by the Taskforce under recommendation 26. Item 30403 is deleted and replaced with new item 30651 for ventral hernia repair involving primary fascial closure by suture. Item 30405 is deleted and replaced with new item 30655 for ventral hernia repair with advancement of the rectus muscles to the midline.

Item 30621 for repair of symptomatic umbilical, epigastric or linea alba hernia is amended to provide for the procedure performed using an open or minimally invasive approach.

Item 30652 is a new item for repair of a recurrent groin hernia, this procedure was previously included in the Taskforce recommended amendments to item 30403 (now replaced by new item 30651, recommendation 26). As repair of a recurrent groin hernia is performed using a different approach to item 30651, this service is listed separately in item 30652.

#### *Oesophageal procedures*

Fifteen (15) items have been deleted and replaced with new items to simplify the arrangements for doctors and patients:

- Items 30527 and 31464 are deleted and replaced with a new item (30756) for anti-reflux operations by any approach, per recommendation 31 of the Taskforce report.
- The fees for the oesophagectomy items are changed to encourage the use of two surgeons (a principle and a co-surgeon – each with an assistant) to improve the safety of highly complex procedures that can take several hours to complete, per recommendations 29 and 30 of the Taskforce report:
  - items 30545, 30550 and 30554 are deleted and replaced with a new item (30750) for oesophagectomy with colon or jejunal interposition graft by any means, performed by one surgeon;
  - items 30547, 30551 and 30556 are deleted and replaced with a new item (30751) for oesophagectomy with colon or jejunal interposition graft by any means, performed by conjoint surgery (item for principal surgeon);
  - items 30548, 30553, 30557 are deleted and replaced with a new item (30752) for oesophagectomy with colon or jejunal interposition graft by any means, performed by conjoint surgery (item for co-surgeon);

- items 30536 and 30535 are deleted and replaced with a new item (30753) for oesophagectomy by any means, involving gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy and anastomosis in the neck or chest, performed by one surgeon;
- Item 30538 is deleted and replaced with a new item (30754) for oesophagectomy by any approach, involving gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy and anastomosis in the neck or chest, performed by conjoint surgery (item for principal surgeon);
- Item 30539 is deleted and replaced with a new item (30755) for oesophagectomy by any approach, involving gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy and anastomosis in the neck or chest, performed by conjoint surgery (item for co-surgeon).

Three (3) items for oesophagectomy by trans-hiatal oesophagectomy have been deleted as they do not reflect current best practice or are redundant due to other oesophagectomy items that provide more appropriate treatment, per recommendation 28 of the Taskforce report. The deleted items are 30541, 30542 and 30544.

Five (5) other oesophageal items have been amended as recommended by the Taskforce. Item 31468 for the repair of para-oesophageal hiatus hernia (recommendation 32) and item 30600 for the repair of a diaphragmatic laceration or hernia (recommendation 35) are amended to clarify the appropriate clinical use of the items. Item 30532 for oesophagogastric myotomy (recommendation 33), item 30560 for repair of an oesophageal perforation (recommendation 34) and item 30601 for repair of a diaphragmatic hernia (recommendation 36) are revised to better reflect contemporary best practice.

#### *Stomach procedures*

Twelve (12) stomach procedure items have been deleted and replaced with three (3) new items to simplify the arrangements for doctors and patients:

- Items 30496, 30497, 30499, 30500, 30502 and 30503 are deleted and replaced with a new item (30760) for vagotomy, per recommendation 38 of the Taskforce report.
- Items 30505, 30506, 30508 and 30509 are deleted and replaced with a new item (30761) for control of bleeding peptic ulcer, per recommendation 39 of the Taskforce report.
- Items 30523 and 30524 are deleted and replaced with a new item (30762) for subtotal or total radical gastrectomy for carcinoma, per recommendation 40 of the Taskforce report.

Item 30763 is a new item for removal of a gastric tumour by endoscopic approach. This item was recommended for listing by the Implementation Liaison Group.

Items for treatment of obstructions (30515), revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (30517), removal of gastric tumour by laparoscopic or open technique (item 30520) and gastrectomy (item 30526) are revised to better reflect contemporary best practice. These changes were recommended by the Taskforce in recommendations 43, 44, 42 and 41 respectively.

#### *Liver procedures*

Seven (7) liver procedures have been deleted and replaced with two (2) new items to simplify the arrangements for doctors and patients:

- Items 30434, 30436, 30437 and 30438 are deleted and replaced with a new item (30770) for removal of contents of hydatid cyst of liver, per recommendation 46 of the Taskforce report.
- Items 30602, 30603 and 30605 are deleted and replaced with a new item (30771) for porto-caval, meso-caval or selective spleno-renal shunt for portal hypertension, per recommendation 47 of the Taskforce report.

Items for marsupialisation of liver cysts (items 30416 and 30417), extended lobectomy (items 30421 and 30430), drainage of liver abscess (items 30431 and 30433) and destruction of primary malignant tumour (items 50950 and 50952) are revised to reflect contemporary best practice. These changes are per recommendations 54, 55, 48, 49, 50, 51, 52 and 53 of the Taskforce report.

#### *Biliary procedures*

Biliary procedures items (30466 and 30467) are deleted and replaced with a new item (30780) for intrahepatic biliary bypass of hepatic ductal system, per recommendation 58 of the Taskforce report.

Item 30446 for laparoscopic cholecystectomy procedures completed by laparotomy is deleted as it duplicates other available cholecystectomy items, per recommendation 57 of the Taskforce report.

Thirteen (13) biliary procedure items have been amended as recommended by the Taskforce:

- Items for operative cholangiography (30439), cholecystectomy (30443, 30445, 30448 and 30449), choledochotomy (30454 and 30455), radical resection of the porta hepatis and hepatic ducts tumour (30461, 30463 and 30464) are revised to reflect contemporary best practice. These changes are per recommendations 59, 60, 61, 63, 64, 65, 69, 70 and 71.
- Item 30472 for the repair of a bile duct injury is amended to clarify it is intended for immediate reconstruction and it cannot be co-claimed with the item for Whipples procedure (30584), per recommendation 66.
- Item 31472 is amended to clarify the procedure is to revise a previous biliary surgery (or to bypass malignancy or a stricture that is unresectable) and it cannot be co-claimed with the item for Whipples procedure (30584), per recommendation 67 of the Taskforce report.
- Item 30450, which previously covered removal of biliary or renal stones, is revised to provide for the extraction of stones from the biliary tract. The removal of renal stones is provided under other MBS items, as noted in recommendation 68 of the Taskforce report.
- Items 30445, 30454, 30472 and 31472 have a fee increase to reflect the time and complexity of the procedures. Item 30449 has a fee decrease to provide a more appropriate fee relativity with item 30455, which is a more complex procedure.

#### *Pancreas procedures*

Two (2) pancreatic procedures items (30586 and 30587) are deleted and replaced with a new item (30790) for pancreatic cyst anastomosis to stomach, duodenum or small intestine, per recommendation 73 of the Taskforce report.

Item 30577 is amended to provide for an initial pancreatic necrosectomy and new item 30791 is listed for subsequent pancreatic necrosectomies, per recommendation 75 of the Taskforce report. The fee for the subsequent procedure is approximately 40 per cent of the fee of the initial procedure.

Item 30583 is amended to provide for distal pancreatectomy with splenic preservation and a new item (30792) is listed for distal pancreatectomy with splenectomy, per recommendation 77 of the Taskforce report. The fee for item 30583 is increased to recognise that preserving the spleen is best practice, wherever possible, and is more difficult than a distal pancreatectomy.

Item 30584 for pancreatico duodenectomy (Whipple's procedure) is revised to include cholecystectomy, pancreatico-biliary and gastro-jejunal anastomosis, per recommendation 74 of the Taskforce. The fee for the item is increased in recognition of the significant time, complexity and aftercare required for this procedure.

#### *Spleen procedures*

Two (2) spleen procedure items are deleted (30597 and 31470) and replaced with a new item (30800) for splenectomy, per recommendation 80 of the Taskforce report.

#### *Oncology procedures*

Three (3) oncology procedures are deleted (30578, 30580 and 30581) and replaced with a new item (30810) for exploration of pancreas or duodenum for endocrine tumour, per recommendation 82 of the Taskforce report.

Item 30419 is amended to remove references to a specific ablative technique to allow doctors flexibility to choose the most appropriate ablation approach for liver tumours, per recommendation 83 of the Taskforce report.

#### *Lymph nodes procedures*

Two (2) lymph nodes procedure are deleted (30096 and 31420) and replaced with a new item (30820) for biopsy of lymph node of the neck, per recommendation 85 of the Taskforce report.

#### *Excision procedures*

Item 30676 for excision of pilonidal sinus or cyst, or sacral sinus or cyst and item 30055 for dressing of wounds under anaesthesia are amended to reflect contemporary best practice, per recommendations 101 and 102 of the Taskforce report.

#### *Bariatric procedures*

Item 31584 for the surgical reversal of adjustable gastric banding, gastric bypass, gastroplasty (excluding by gastric plication) is amended to clarify it has application to the reversal, revision or conversion of a previous bariatric procedure. This change was recommended by the Taskforce and can be found in the bariatric items section of the report.

New item 31585 is listed to provide for the removal of an adjustable gastric band. This item was recommended for listing by the Implementation Liaison Group.

#### Orthopaedic amendments

Orthopaedic services have been changed to reflect contemporary clinical evidence and practice. Items for orthopaedic services have been listed, amended and deleted to implement the Government's response to the MBS Review Taskforce recommendations. Some of the recommendations have been modified by the orthopaedic Implementation Liaison Group to support the effective and practical implementation of the Government response to the Taskforce recommendations.



The Taskforce report on orthopaedic services can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce>. The major changes are described below:

*General orthopaedic procedures – bone graft procedures*

Eighteen (18) items for bone grafting (47726, 47729, 47732, 48200, 48203, 48206, 48209, 48212, 48215, 48218, 48221, 48224, 48227, 48230, 48233, 48236, 48239 and 48242) are deleted and replaced with five (5) new items, per recommendation 1 of the Taskforce. The new items (48245, 48248, 48251, 48254 and 48257) are based on the type of graft and the complexity of the procedure required to harvest the graft. They replace an assortment of existing items with varying degrees of clarity, some of which were based on the site of insertion while others were based on the type or size of the graft.

The new items are generally intended to be performed in conjunction with a primary procedural item, but they may infrequently be used as a standalone medical service for procedures such as the harvesting and insertion of an osteochondral graft.

*General orthopaedic procedures – osteotomy and osteectomy procedures*

Ten (10) items across the orthopaedic schedule are amended to remove the term osteotomy (removing part of a bone), per recommendation 2 of the Taskforce report. These include items 48400, 48403, 48406, 48409, 48412, 48415, 48421, 48424, 48427 and 47501. This change will clarify the items and limit the circumstances in which a separate item is claimed for the removal of bone. Items will be created or amended where the procedure is required for a specific reason, per the relevant sub-specialty specific recommendations.

*General orthopaedic procedures – joint and tendon procedures*

General joint item 50115 is amended to remove spinal manipulation from the descriptor to make it distinct from MBS items for spinal procedures which are the appropriate items to claim for spinal manipulation, per recommendation 9 of the Taskforce report.

Seven (7) general joint items (50100, 50102, 50103, 50104, 50106, 50109 and 50127) are deleted and replaced with items specific to each anatomical site, per recommendation 9 of the Taskforce report. The deleted items include procedures for joint arthrotomy, joint arthroplasty, joint stabilisation and joint arthrodesis.

Four (4) general tendon items (47957, 47963, 47966 and 47969) are deleted and replaced with items specific to each anatomical site, per recommendation 7 of the Taskforce report. The deleted items include procedures for tendon lengthening, tenotomy, tendon or ligament transfer and tenosynovectomy.

The new items will be included within each of the following sub-specialties; knee, hand and wrist, shoulder and elbow, hip, foot and ankle. This recognises the nature of contemporary orthopaedic clinical practice, with many doctors specialising in a type of orthopaedic surgery in a particular body area.

Tendon repair item 47954 is amended to include the words ‘traumatic tear or rupture’ to specify the clinical indication for the service and to exclude the co-claiming with item 39330 (neurolysis) or other peripheral nerve repair items, per recommendation 7 of the Taskforce report.

*Hand and wrist – revision procedures (fasciectomy, joint, carpal tunnel and stump amputation)*

Ten (10) items have been listed or amended to account for the additional complexity of revision procedures, per recommendations 52 of the Taskforce report. Revision procedures are typically more complicated than the primary surgery because of distorted anatomy and scar tissue. The new items will provide clarity and consistency in clinical practice and reduce variation in claiming.

- Items 46387, 46390, 46393, 46394, 46395 are listed or amended for revision of fasciectomy for Dupuytren's contracture performed on the hand and wrist.
- Items 39332 and 39339 are listed for carpal and cubital tunnel revision performed on the hand and wrist.
- Item 46483 is amended for revision of stump amputation performed on the hand and wrist.
- Items 49210 and 46322 are listed or amended for revision of stump amputation performed on the hand and wrist.

#### *Hand and wrist – amputation procedures*

Two (2) hand amputation procedures (44325 and 44328) are amended to better describe the anatomical location of the amputation, per recommendations 50 and 64 of the Taskforce report. These items must be performed in a hospital setting and are expected to be performed for elective and trauma care.

Seven (7) digit amputation procedures (46464, 46465, 46468, 46471, 47474, 46477 and 46480) are amended to allow a surgical assist item to be co-claimed. This is intended to improve patient safety and promote better health outcomes, per recommendations 50 and 64 of the Taskforce report.

Six (6) items (46465, 46468, 46471, 47474, 46477 and 46480) have also been amended to provide a more accurate and complete description of the procedures covering all routine steps and to differentiate the services by the number of 'rays' treated. A ray runs the tip of the digit to proximal metacarpal base of that digit, including phalanges and metacarpal. These items must be performed in a hospital setting and are expected to be performed for elective and trauma care. Item 46464 can be performed in hospital or out-of-hospital.

Two (2) items for primary and revision amputations, for congenital abnormalities of the hand (46483 and 50396) are amended. Item 46483 is amended to clarify that bone shortening, excision of a neuroma and removal of nail bed remnants are part of the surgery (if performed). This item can be performed in hospital or out-of-hospital in an elective or trauma setting. Item 50396 is amended to include amputations for congenital abnormalities or duplications of the hands or feet. The item is expected to be performed for patients in hospital for elective and trauma care.

#### *Hand and wrist – bone procedures*

Bone procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 51 of the Taskforce report.

Two (2) items (46402 and 46405) are deleted and replaced with a new item (46401) for operative treatment of non-union of the phalanx or metacarpal. This item can be co-claimed with the bone graft section. The fee is comparable to item 46396 (osteotomy of phalanx).

Item 46396 is deleted as osteotomy of the phalanx and metacarpal requires internal fixation which is covered under item 46399. Item 46399 is amended to add the term 'per bone' to the descriptor clarifying the appropriate use of the item.

A new item for resection of metacarpal boss (46493) is listed. This procedure would most likely have been performed under deleted osteectomy item 46396. The new item has a fee similar to deleted item 46396.

*Hand and wrist – Dupuytren’s disease procedures*

Five (5) items for Dupuytren’s disease (46372, 46375, 46378, 46379 and 46380) are amended or listed to create a tiered structure that provides a more accurate and complete description of the procedures. The new items are differentiated by the number of ‘rays’ treated. The amended items aim to reduce the variation in billing practice and renumerate fasciectomy procedures based on the complexity of the surgery performed, per recommendation 52 of the Taskforce report.

Two (2) items (46366 and 46369) are consolidated under item 46370 to provide a single item for percutaneous fasciotomy that more clearly describes the component procedures. Joint release item 46381 is amended to better reflect contemporary clinical practice. This item was not incorporated with the fasciectomy items for Dupuytren’s contracture as it is not an inherent part of fasciectomy to treat Dupuytren’s contracture, but adds complexity to the surgery and increases the duration of post-operative follow-up when required.

*Hand and wrist – finger nail procedures*

Three (3) items for reconstruction of nail bed laceration, wedge and partial resection for ingrown finger or thumb nail (46486, 46528 and 46531) are amended to provide a more accurate and complete description of the procedures that better reflects contemporary clinical practice, per recommendation 53 and 73 of the Taskforce report.

Two (2) items (46534 and 46489) are amended to restrict the items to be performed in hospital and provide a more accurate and complete description of the procedure that better reflects contemporary clinical practice.

Item 46534 is amended to allow a surgical assist item to be co-claimed. The procedure affects a difficult anatomical region and requires careful retraction by an assistant to reduce risk to the patient and promote better outcomes.

Item 46516 is deleted as removal of a digital nail is covered under amended item 46513. Item 46513 is amended to remove reference to where the service is performed.

*Hand and wrist – ganglion procedures*

Ganglion procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 54 of the Taskforce report.

Item 46494 is deleted as excision of ganglion or mucous cyst of the interphalangeal, metacarpophalangeal or carpometacarpal joints should be performed under item 46495. Item 46495 is amended to specify the anatomical location of the joint to provide greater clarity to practitioners regarding how the item should be used. A surgical assist item can be co-claimed to support improved patient outcomes.

Item 46498 is amended to specify that the operation includes flexor tenosynovectomy, sheath excision, and skin closure by any method as inherent components of the service. A surgical assist item can be co-claimed to support improved patient outcomes.

Items for excision of dorsal wrist joint ganglion (46500 and 46502) are amended to specify that the procedure includes wrist joint arthrotomy, synovectomy and any capsular/ligament repair (if performed).

*Hand and wrist – infection procedures*

Infection procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 55 of the Taskforce report.

Two (2) items (46459 and 46462) are deleted and replaced with the general surgery osteomyelitis and septic arthritis items.

Drainage items (46522 and 46519) for infection of the hand (middle palmar, thenar, hypothenar or dorsum spaces) and flexor tendon are amended to provide a more accurate and complete description of the procedures that better reflects contemporary clinical practice.

*Hand and wrist – inflammatory arthritis procedures*

Inflammatory arthritis procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 56 of the Taskforce report.

Five (5) items (46348, 46351, 46354, 46357 and 46360) are amended for flexor tenosynovectomy distal to lumbrical origin. The items are for one ‘ray’, two rays, three rays, four rays and five rays respectively. A ray runs the tip of the digit to proximal metacarpal base of that digit, including phalanges and metacarpal.

Three (3) new tenosynovectomy items (46335, 46340 and 46341) are listed for extensor and flexor tendons at wrist level and distal to the wrist. Tenosynovectomy item (46339) is amended to clarify it is for digital flexor tendons and includes flexor tenolysis, release of the median nerve and carpal tunnel release.

Two (2) new items (46364 and 46365) are listed for digital sympathectomy and excision of rheumatoid nodules respectively. Item 46365 is listed with a fee equivalent to item 46336, which is a procedure of similar complexity.

Item 46336 is amended to clarify it is for synovectomy of the interphalangeal, metacarpophalangeal or carpometacarpal joints and cannot be performed with item 46495 for excision of a ganglion or mucous cyst.

*Hand and wrist – joint procedures*

Joint procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 57 of the Taskforce report. Six (6) items (46300, 46303, 46324, 46325, 46330 and 46333) are amended to provide a more accurate and complete description of the procedures, that better reflect contemporary clinical practice.

Five (5) items for total replacement arthroplasty or hemiarthroplasty of the interphalangeal or metacarpophalangeal joint (46309, 46312, 46315, 46318 and 46321) are amended to clarify that they includes prosthetic replacement as a mandatory component of the procedure. Where they are performed; synovectomy, tendon transfer, realignment or ligament reconstruction are all components of the procedure. New item 46322 is listed as revision procedure for prosthetic replacement arthroplasty or hemiarthroplasty.

Four (4) items (46306, 46307, 46327 and 46447) have been deleted. Items 46306 and 46307 are replaced with a new item 46308 for volar plate or soft tissue interposition arthroplasty of the interphalangeal joint or metacarpophalangeal joint. Items 46327 and 46447 are

consolidated under other items in the hand and wrist section (46324-46492, 46444 or 46492) as they are not independent procedures.

*Hand and wrist – nerve procedures*

Nerve procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 58, 59 and 71 of the Taskforce report.

Five (5) items (39303, 39309, 39315, 39318 and 39324) for delayed repair of cutaneous nerve, nerve trunk, nerve graft and neurectomy are amended to better reflect contemporary clinical practice.

Two (2) new items (39328 and 39329) are listed for the removal of a tumour from the deep peripheral nerve and neurolysis of the radial, median or ulnar nerve trunk in the forearm respectively.

Three (3) new items (39336, 39342 and 39345) are listed for primary and revision procedures to the ulnar nerve. The new items will prevent inconsistent billing practices, define anatomical landmarks and more clearly reflect the increased complexity of these procedure procedures.

Three (3) items (39321, 39330 and 39331) are amended to more precisely define the circumstances in which the items can be claimed and make clear the inherent components of the procedures.

Three (3) items for nerve repair and nerve graft (39306, 39315 and 39318) are amended to restrict co-claiming against item 39330.

Two (2) new items (39307 and 39319) are listed to provide a benefit for reconstruction of a digital or cutaneous nerve or nerve trunk using biological or synthetic nerve conduit. The items are required to cover a new technique and reflect contemporary clinical practice. The lack of a specific item for this procedure is resulting in inconsistent billing practices, with most clinicians charging items for a nerve graft with or without neurolysis.

*Hand and wrist – wrist arthroplasty procedures*

Wrist arthroplasty procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 62 of the Taskforce report.

Three (3) total replacement arthroplasty items (49209, 49210 and 49211) are amended to clarify when the services should be performed. Item 49209 is amended to clarify that the item covers prosthetic replacement of the ulnar head or prosthetic replacement of the distal radioulnar joint. Item 49210 is amended to clarify that the item covers total arthroplasty of the ulnar head or the distal radioulnar joint. Item 49211 is deleted as the procedure can be performed under amended item 49210.

Distal radioulnar joint resection arthroplasty item 46345 is amended to provide a more accurate and complete description of the procedure that better reflects contemporary clinical practice.

A new item (49213) for Sauve-Kapandji release (fusion of distal radioulnar joint with creation of a pseudoarthrosis of the ulnar just proximal to the fusion) is listed to provide an

accurate and complete description of the procedure, which is currently being claimed under multiple MBS items.

*Hand and wrist – tendon and soft tissue / reconstructive procedures*

Tendon and soft tissue procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 60, 61 and 70 of the Taskforce report.

Seven (7) items (46363, 46408, 46411, 46414, 46417, 46423, 46450, 46504, 46507 and 46510) are amended to provide a more accurate descriptor and to cover all routine surgical steps of procedure. Item 46363 will allow a surgical assist item to be co-claimed with the procedure.

Two (2) items (46429 and 46435) are deleted and replaced with a new item (46434) for delayed flexor tendon repair, inclusive of tenolysis if performed.

A new item (46367) for De Quervain's release is listed. This condition is linked to trigger finger, which requires complex and time-intensive surgery. A new item with an accurate and complete description will reduce variation in the items being claimed for the procedure. Item 47972 is deleted as the procedure can be performed under items 46363 or 46367.

Four (4) items (46408, 46411, 46414 and 46417) for tendon reconstruction are amended to specify the context each item can be claimed under.

Two (2) items (46426 and 46432) for repair of a digit tendon are amended to specify that the procedures are claimable per tendon with a maximum of two per digit.

*Hand and wrist – diagnostic and therapeutic procedures*

Diagnostic and therapeutic procedures are updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 63 of the Taskforce report.

Six (6) items (49206, 49212, 49215, 49221, 49224 and 49227) for carpectomy, arthrotomy, reconstruction, debridement and stabilisation are amended to specify inherent components of each procedure.

Two (2) wrist arthrodesis items (49200 and 49203) are amended to remove references to bone grafting. If a bone graft is required for wrist arthrodesis procedures, an additional item should be selected from the new bone graft table.

Four (4) new items (49236, 49219, 49220 and 49239) are created for diagnostic and therapeutic arthroscopic joint procedures and excision of the pisiform.

*Hand and wrist – dislocation procedures*

Dislocation procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 65 of the Taskforce report.

Five (5) items for dislocation procedures are amended to specify that these procedures include prosthetic replacement as a mandatory component. Separate items for synovectomy, tendon transfer, realignment or ligament reconstruction cannot be co-claimed.

Four (4) items (46300, 46330, 46333 and 47027) are amended to specify the inherent components of each procedure.

Two (2) items (47036 and 47039) are deleted and replaced with amended items 47042 and 47045 respectively to simplify the MBS and provide items that can be claimed for either the interphalangeal or metacarpophalangeal joint.

*Hand and wrist – fracture procedures*

Fracture procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 66, 67 and 68 of the Taskforce report.

Five (5) items (47348, 47354, 47357, 47033 and 47351) for the treatment of fracture of the carpus are amended to provide a more accurate and complete description of the procedure; specifically, stating where the services require cast immobilisation or internal fixation.

Three (3) items (47384, 47386 and 47393) are amended to provide a more accurate and complete description of the procedure that better reflect contemporary clinical practice.

Item 47378 is deleted and replaced with amended item 47387 to provide a single item for the treatment of fracture of the shaft of the radius or ulna.

Three (3) items for hand fracture (47307, 47310, 47313) are amended to provide a more accurate and complete description of the procedure and specify the type of fixation required to fulfil the requirements of the descriptor.

Items 47301 and 47304 are amended to specify the items can be claimed once per fractured bone.

*Hand and wrist – mallet finger procedures*

Item 46441 for treatment of mallet finger has been updated to include joint release and tenolysis in an effort to more clearly define the inherent components of the procedure, per recommendation 69 of the Taskforce report.

*Foot and ankle – amputation procedures*

Nine (9) amputation procedures (44338, 44342, 44346, 44350, 44354, 44358, 44359, 44361 and 44364) are amended to reflect modern clinical practice and to clarify the requirements of the procedures, per recommendation 116 of the Taskforce report.

The amendments clarify which procedures include resection of the bone or joint, excision of neuroma and skin cover with homodigital flaps and specify the correct billing arrangements where multiple rays or digits are amputated.

*Foot and ankle – bone procedures*

Bone procedures have been updated to modernise the MBS and ensure that items provide rebates for high-value services, per recommendation 118 of the Taskforce report.

Four (4) items for bone procedures (48400, 48403, 48406 and 48409) of the foot and ankle are amended to clarify the requirements of each procedure.

General exostosis item 47933 is deleted and replaced with a new item (48430) specific to the foot and ankle which clarifies the included components in order to prevent inappropriate co-claiming with procedures at the same anatomical site.

Two (2) new items (48419 and 48420) are created for osteotomy of the distal tibia for correction of deformity. The new items are differentiated by the requirement for internal fixation. The items are required to account for the recommended removal of item 48418 and limitation of item 48421 to the distal tibia (Recommendation 47).

Two (2) items are created for treatment of non-union or malunion of the ankle, hindfoot, midfoot or forefoot. The items are required as at present no specific item exists for the treatment of bone non-union, which may occur after fracture fixation.

*Foot and ankle – bunion procedures*

Bunion procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 119 of the Taskforce report. Six (6) items (49827, 49830, 49833, 49836, 49837 and 49838) are amended to clarify the requirements of each procedure. The items represent increasing complexity; from soft tissue correction, soft tissue with osteotomy to soft tissue with internal fixation.

*Foot and ankle – toe nail procedures*

Toe nail procedures will be updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 120 of the Taskforce report. Three (3) items for ingrowing nails (47915, 47916 and 47918) are amended to more accurately describe a complete medical procedure and prevent inappropriate use.

*Foot and ankle – ganglion procedures*

Four (4) new ganglion items (49881, 49884, 49887 and 49890) have been listed for primary and revision procedures to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 121 and 122 of the Taskforce report. Previously there will be no specific MBS items for excision of ganglion, bursae or mucinous cysts in the foot and ankle.

*Foot and ankle – infection procedures*

Infection procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 123 of the Taskforce report. Item 47912 has been deleted because this procedure is a minor task that should be accommodated within the fee of an MBS attendance item. Less serious infections may be claimed as part of a consultation or using item 30219 for a small cyst. More serious infections such as septic arthritis and osteomyelitis are subsidised under other MBS items.

*Foot and ankle – inflammatory arthritis procedures*

Inflammatory arthritis procedures have been updated to modernise the MBS and ensure that items provide rebates for high-value services, per recommendation 124 of the Taskforce report.

Two (2) new items (49771 and 49772) are listed for synovectomy of a major ankle tendon and excision of rheumatoid nodules respectively. The items provide a complete medical service and more clearly reflect modern clinical practice.

Item 49863 is deleted and replaced with amended item 49860 to provide a single item for synovectomy of one or more metatarsophalangeal joints.

*Foot and ankle – nerve procedures*

Nerve procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 125 of the Taskforce report.



Item 49866 is amended to clarify it is for the excision of intermetatarsal or digital neuroma and provide a more accurate and complete description of the procedure that better reflects modern clinical practice.

Three (3) new items (49773, 49774 and 49775) are listed for excision of neuroma, release of tarsal tunnel and revision tarsal tunnel release. Item 49774 is required as no benefit is currently available for the procedure; leading to inconsistent billing practices and multiple claiming of item 39330 (neurolysis). The revision items are required as these procedures are more complicated than the primary procedures (due to scar tissue, nerve adherence and the need to make different incisions).

*Foot and ankle – arthrodesis procedures*

Arthrodesis procedures are updated to create items that better reflect the range of complexity associated with these procedures, per recommendation 126 of the Taskforce report.

Five (5) new items (49777, 49778, 49779, 49780 and 49781) are listed for primary and revision arthrodesis of the midfoot joint to account for the deletion of item 50109. The items are required as at present the MBS does not provide a benefit for midfoot joint fusion.

Four (4) additional items (49789, 49790, 49742 and 49744) are listed for primary and revision bilateral first metatarsophalangeal joint arthrodesis and extended ankle and hindfoot arthrodesis. Item 49791 is listed for hallux interphalangeal or lesser metatarsophalangeal joint arthrodesis.

Four (4) arthrodesis items (49712, 49815, 49845 and 50118) for the ankle, foot, first metatarsophalangeal joint and subtalar joint are amended to clarify the techniques which can be used for each procedure. A fee increase has been applied to reflect their complexity relative to similar procedures for the wrist, elbow and tibia.

Two (2) new items (49740 and 49776) are listed for revision procedures for primary ankle arthrodesis and hindfoot joint arthrodesis respectively.

Seven (7) new items (49792, 49793, 49794, 49795, 49796 and 49798) are listed for lesser toe surgery to account for the deletion of item 49848 for correction of the claw or hammer toe.

*Foot and ankle – arthroplasty procedures*

Arthroplasty procedures have been updated to modernise the MBS and ensure that items provide rebates for high-value services, per recommendation 127 of the Taskforce report.

Six (6) new items (49783, 49784, 49785, 49786, 49787 and 49788) are listed for interpositional arthroplasty of an increasing number of metatarsophalangeal or tarsometatarsal joints.

Seven (7) items (49715, 49716, 49717, 49839, 49857, 49821 and 49824) are amended to clarify the components that are included in each procedure, clarify the circumstances in which it is appropriate to claim the items and limit inappropriate co-claiming.

*Foot and ankle – arthroscopy procedures*

Arthroplasty procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 128 of the Taskforce report.

Item 49703 is amended to clarify that the procedure includes cartilage treatment, removal of loose bodies, synovectomy and excision of joint osteophytes by arthroscopic means.

Two (2) new items (49730 and 49732) are listed for arthroscopic surgery of the hindfoot and endoscopy of large tendons of the foot. The items account for the deletion of item 50102, preventing gaps from appearing in the MBS and preserving access for patients.

*Foot and ankle – soft tissue procedures*

Soft tissue procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 129 of the Taskforce report.

Eight (8) new items (49761, 49762, 49763, 49764, 49765, 49766, 49767 and 49768) are listed for metatarsophalangeal joint stabilisation. The items are required to account for the deletion of item 50106 (recommendation 9 of the report). This prevents gaps from appearing in the MBS and preserves patient access. The items are differentiated by the number of metatarsals requiring stabilisation.

Four (4) items (49706, 49709, 49818 and 49854) are amended to clarify the components that are included under each procedure, clarify the circumstances in which it is appropriate to claim the items and limit inappropriate co-claiming.

Two (2) new items (49734 and 49738) are created for arthrotomy of the ankle and talonavicular joint stabilisation. The items account for the deletion of items 50103 and 50106 respectively.

*Foot and ankle – tendon procedures*

Tendon procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 130 of the Taskforce report.

Seven (7) items (49724, 49727, 49728, 49712, 49703, 49806 and 49809) are amended to clarify the components that are included in each procedure, clarify the circumstances in which it is appropriate to claim the items and limit inappropriate co-claiming.

Two new items (49814 and 49736) are listed for hindfoot tendon reconstruction with osteotomy and major tendon transfer. The new items will be a complete procedure.

*Foot and ankle – non-surgical management*

Non-surgical management items have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 131 of the Taskforce report.

Six (6) items (47594, 47606, 47627, 47633, 47642 and 47651) are deleted and replaced with a single item (47595) for non-surgical management. This will reflect the appropriate use of non-surgical treatment items for several fractures to the same limb. Non-surgical treatment is often the same for all injuries, such as the application of a walking boot.

*Foot and ankle – closed reduction of fractures and dislocation procedures*

Closed reduction of fractures and dislocation procedure items have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 132 of the Taskforce report.

Five (5) items (47063, 47597, 47621, 47663 and 47069) are amended to clarify the components that are included in each procedure, clarify the circumstances in which it is appropriate to claim the items and limit inappropriate co-claiming.

Three (3) items (47636, 47645 and 47654) are deleted and replaced with a single item for closed reduction of a metatarsal fracture (47637). The consolidation is possible because there is no difference in closed treatment between one metatarsal and three or more metatarsals. MBS data shows that items 47645 and 47654 have low service volumes.

Item 47609 is deleted and replaced with item 47612. This service can be consolidated in item 47612 because hindfoot fractures are more likely to have intraarticular involvement. All surgeries previously claimed under item 47609 are expected to be claimed under item 47612.

#### *Foot and ankle – other fractures*

Fracture items have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 133, 134, 135, 136 and 137 of the Taskforce report.

Three (3) items (47639, 47648 and 47657) for metatarsal fractures are amended to specifically list the parts of the procedure included if performed. Component procedures include arthrotomy at the fracture site, washout of joint, removal of loose fragments or intervening soft tissue, and capsule repair.

Three (3) items (47066, 47600 and 47603) for ankle fractures are amended to clarify that the items include; arthrotomy, washout of joint, removal of loose fragments or intervening soft tissue, and capsule repair as an inherent part of the procedure.

Two (2) items (47615 and 47618) for hindfoot fracture have been amended. Amending ‘calcaneum or talus’ to ‘hindfoot’ will allow the items to provide reimbursement for all hindfoot bones. This will remove the need for a new item for navicular or cuboid fractures.

Two (2) items (47624 and 47630) for cuneiforms, tarsometatarsal joints and lisfranc injuries are amended to specifically list the parts of the procedure included, if performed. Component procedures include arthrotomy at the fracture site, washout of joint, removal of loose fragments or intervening soft tissue, and capsule repair.

Three (3) items (47666, 47672 and 47678) for toe fractures are amended to specifically list the parts of the procedure included, if performed, and clarify that the items are to be claimed once per foot. Item 47072 is deleted and consolidated with the other items for toe dislocation.

#### *Foot and ankle – tendon procedures*

Tendon procedures are updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 138 of the Taskforce report. Two (2) items (49718 and 49800) for toe fractures are amended to specifically list the parts of the procedure included, if performed, and clarify that the items are to be claimed once per tendon.

#### *Shoulder and elbow – arthroscopic shoulder procedures*

Four (4) open and arthroscopic shoulder surgery procedures (48930, 48933, 48936 and 48957) have been deleted and replaced with new items based on the type of procedure not the technique used to perform it (open or arthroscopic). The new items remove the distinction between open and arthroscopic surgical techniques as they are of similar complexity and result in the same clinical outcome. It is hoped the amended descriptors will simplify the

items for doctors and consumers by focusing on the requirements of the procedure. The changes include:

- Items 48930, 48933 and 48957 are deleted and replaced with a new item (48958) for joint stabilisation repair of the shoulder, per recommendation 78 of the Taskforce report. Item 48958 is excluded from being co-claimed with other shoulder surgeries by arthroscopy.
- Item 48936 is deleted with its function continuing under amended synovectomy shoulder item 48954, which will encompass procedures performed by open or arthroscopy techniques per recommendation 80 of the Taskforce report. Amended item 48954 is excluded from being co-claimed with other shoulder surgeries by arthroscopy.

#### *Shoulder and elbow – bicep tenodesis*

A new item (48972) for bicep tenodesis is listed to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 76 of the Taskforce report. This item is required to account for the deletion of item 47966 (general tendon and ligament transfer).

#### *Shoulder and elbow – arthroplasty and arthrotomy procedures*

Arthroplasty and arthrotomy procedures are amended to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 77 and 82 of the Taskforce report.

Four (4) items (48918, 48924, 49115 and 49117) are amended to 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 48912 is consolidated with the septic arthritis items. The item it is not an independent procedure and should be performed as part of other shoulder procedures. Cases of septic arthritis are covered by the consolidated and updated osteomyelitis items.

#### *Shoulder and elbow – ligament and joint stabilisation procedures*

Joint stabilisation procedures have been amended to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 78 and 84 of the Taskforce report.

Three (3) items (48930, 48933 and 48957) for open and arthroscopic joint stabilisation are a deleted and replaced with a new item (48958). This makes it easier for clinicians to determine which items to use as open and arthroscopic joint stabilisations are different surgical methods that result in the same clinical outcome.

Item 49103 is deleted and replaced with two new items (49104 and 49105) for chronic and acute ligament repair. This will fill a gap in the services subsidised under the MBS as there was previously no specific MBS item for surgery to repair an acute traumatic injury of the elbow.

#### *Shoulder and elbow – synovectomy procedures*

Synovectomy procedures have been amended to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 80 and 81 of the Taskforce report.

Item 48936 has been deleted and replaced with item 48954. This change will assist in making the MBS more user-friendly.

Item 48942 is amended to guide appropriate use with the proposed bone grafting items (Recommendation 7). The change recognises that bone grafting is an inherent part of the procedure and should not be claimed separately.

*Knee procedures – arthroscopy procedures*

Six (6) knee arthroscopy procedures (49557, 49558, 49559, 49561, 49562 and 49563) have been deleted and replaced with nine (9) new items (49570, 49572, 49574, 49576, 49578, 49580, 49582, 49584 and 49586). These items are differentiated by surgical complexity and clinical indication to clarify the intended use of each procedure for doctors and patients. The new items will aim to reduce the variation in billing practice and the number of inappropriate knee arthroscopies performed on patients with uncomplicated osteoarthritis, per recommendation 38 of the Taskforce report.

*Knee procedures – replacement and revision procedures*

Four (4) knee replacement procedures (49518, 49519, 49521 and 49524) have been amended to provide more accurate and complete descriptions of their procedural components. The items will also be restricted from being co-claimed with the bone grafting items (48245, 48248, 48251, 48254 and 48257), as bone grafting is included as a component of the knee replacement procedural items if performed. The amended items aim to reduce the variation in claiming practice and renumerate knee replacement procedures based on the complexity of the surgery performed, per recommendation 29 of the Taskforce report.

Four (4) knee revision procedures (49527, 49530 and 49533) have been amended to provide a more accurate and complete description of their procedural components. Formerly, this was done through references to bone grafting. However, the distinction between ‘major’ and ‘minor’ bone grafting was unclear and was not an accurate indicator of complexity. Complexity is now based on the components being revised. A new item (49525) is listed for revision of uni-compartmental arthroplasty.

*Hip procedures – primary replacement procedures*

Three (3) primary hip replacement procedures (49318, 49319 and 49321) have been amended to provide more accurate and complete descriptions of their procedural components. The items have also been restricted from being co-claimed with the bone grafting items (48245, 48248, 48251, 48254 and 48257), as bone grafting is included as a component of the knee replacement procedural items if performed. The amended items aim to reduce the variation in practice and renumerate hip replacement procedures based on the complexity of the surgery performed, per recommendation 106 of the Taskforce report.

*Hip procedures – revision replacement procedures*

Nine (9) revision hip replacement procedures (49312, 49324, 49327, 49330, 49333, 49336, 49342, 49345 and 49346) have been deleted and replaced with 14 new items (49372, 49374, 49376, 49378, 49380, 49382, 49384, 49386, 49388, 49390, 49392, 49394, 49396 and 49398) that:

- include bone grafting as a component of the hip replacement if performed; and
- are differentiated by surgical complexity and the clinical indication for the surgery to clarify the intended use of the procedures for doctors and patients. In particular, the reference to the components replaced, the requirement for femoral osteotomy and the degree of bone grafting required, which are key indicators of complexity in revision hip replacement.

The new items aim to reduce the variation in practice and renumerate revision hip replacement procedures based on the complexity of the surgery performed, per recommendation 107 of the Taskforce report.

*Hip procedures – dislocation procedures*

Two (2) items (47048 and 47051) have been deleted and replaced with four new items for hip dislocations (47047, 47049, 47052, and 47053), per recommendation 109 of the Taskforce report. These new items distinguish between the treatment of native and prosthetic hips. This is required to reflect 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.

*Hip procedures – tendon procedures*

Tendon procedures have been amended to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 112 of the Taskforce report.

Three (3) new items for hip tendon repairs (47964, 47955 and 47956) have been listed. These items were created in response to the recommended limitation of item 47954 to traumatic injury and the deletion of items 47957, 47963 and 47966. The new items also reflect modern clinical practice, which has changed over the last 10 years due to improved diagnostic imaging.

*Hip procedures – osteotomy procedures*

Osteotomy procedures have been amended to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 115 of the Taskforce report.

Two (2) new items (48423 and 48426) are listed for pelvic and femoral osteotomy in adult patients. The exclusion for femoroacetabular impingement in amended item 48424 has not been included in this new item because this was relevant to osteectomy, which is no longer in the item descriptor.

*Paediatric – osteotomy procedures*

Two (2) items for osteotomy of the hip (48424 and 48427) have been amended, per recommendation 140 of the Taskforce report. Distinguishing the items by anatomical site rather than the requirement for internal fixation more accurately reflects differences in clinical practice.

An additional item (50394) has been amended to remove reference to ‘acetabular dysplasia’ as there is no clear definition of this term and it is not a useful component of the item descriptor. The new descriptor provides a clearer description of the procedure, per recommendation 141 of the Taskforce report.

A new item (50395) has been created for distillation of the greater trochanter, per recommendation 142 of the Taskforce report. There was previously no item for trochanteric transfer where it is moved distally to address a Trendelenburg gait in patients with Perthes’ disease or developmental dysplasia of the hip. Listing an item for this procedure reflects modern clinical practice and will prevent inappropriate use of items that do not accurately describe clinical practice, such as the femoral osteotomy item.

*Paediatric – hip dysplasia and dislocation procedures*

Hip dysplasia and dislocation procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendation 143 of the Taskforce report.

Three (3) items (50349, 50650 and 50658) are deleted and replaced with amended item 50654 for hip dislocation or dysplasia. Consolidating the items will assist in making the MBS more user-friendly and consistent. The changes to the descriptor for item 50654 account for the consolidation of these items and reflect modern clinical practice.

Item 50353 is deleted and replaced with amended item 50352. These items cover similar procedures. Consolidating the items will assist in making the MBS more user-friendly and consistent. The change from 'congenital dislocation' to 'developmental dysplasia' reflects modern clinical terminology. Item 50351 has also been amended to include the application of a hip spica to create a descriptor which represents a complete medical service.

*Paediatric procedures – slipped capital femoral epiphysis*

Item 47525 will be deleted and replaced with two new items (47983 and 47984) for slipped capital femoral epiphysis. These paediatric-specific items have been created to prevent inappropriate use of item 47525, per recommendation 144 of the Taskforce report.

*Paediatric – general paediatric hip procedures*

General paediatric hip procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 145, 146 and 147 of the Taskforce report.

Four (4) items (50375, 50378, 50381 and 50384) are amended to clarify that lengthening or division of the adductors and psoas are mandatory components of the procedure and cannot be co-claimed with other items.

Item 50387 is deleted as the item no longer represents modern practice and is obsolete, as evidenced by low service volume. Item 50393 is amended to provide a descriptor with a clearer definition of the procedure as it applies to paediatric patients.

*Paediatric – deformity procedures*

Deformity procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 150, 151 and 152 of the Taskforce report.

Two (2) items (50315 and 50318) are deleted and replaced with amended item 50321. Consolidating the items will make it simpler to claim and not reduce patient access, as the deleted items have low service utilisation.

Two (2) items (50324 and 50333) are amended to more clearly define the components of each procedure.

Item 50327 is deleted and replaced with items 50321 and 50324. Item 50327 had very low service volumes and a separate bilateral item was not required. Clinicians may instead use updated items 50321 or 50324, applying the multiple operations rule (as appropriate) for multiple claims.

An additional item (50335) is listed for vertical, congenital talus procedures. This new item is required because item 50336 no longer represented first-line treatment for vertical talus deformity. Modern practice is now to reverse Ponseti casting followed by stabilisation of

talonavicular joint via percutaneous K-wire fixation and Achilles tenotomy. No item currently exists for this technique

Item 50342 is deleted and replaced with item 50339. The descriptor for item 50339 has been changed to account for this consolidation and variation in technique. It has also been changed to address ambiguities in the current wording regarding the appropriate circumstances in which the procedure can be performed.

*Paediatric – knee and leg procedures*

Knee and leg procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 155, 156 and 157 of the Taskforce report.

Two (2) items (50363 and 50366) have been consolidated under item 50369. These items represent very similar procedures and have low service volumes. Consolidating these items into a single item will make the MBS more user-friendly.

Four (4) items (50354, 50357, 50360 and 50372) have been amended to more clearly define the inherent components of each procedure and specify the specific location of the procedure the item describes.

*Paediatric – amputations and reconstruction procedures for congenital deformity*

A new item (50428) has been listed for percutaneous drilling of osteochondritis dessicans or other osteochondral lesions. This new item is required because no item currently exists for this procedure. The procedure was formerly reimbursed using item 49559 (knee arthroscopic surgery), which does not accurately describe the procedure.

Item 50426 is amended to more clearly define the inherent components of the procedure. These changes will be implemented per recommendation 158 of the Taskforce report.

*Paediatric – neck shoulder and elbow procedures*

Item 50402 is deleted and its function consolidated under item 44133 for unipolar release, per recommendation 159 of the Taskforce report. Unipolar and bipolar release should be claimed under a single item because the procedures are similar and there are very low service volumes across the two items.

*Paediatric – limb-lengthening procedures*

Three (3) limb-lengthening procedures (50300, 50303 and 50306) have been amended, per recommendation 162 of the Taskforce report. Items 50300 and 50303 are amended to allow the items to be claimed more than one in a 12-month period. This is intended to allow children with congenital syndromes affecting multiple joints in multiple limbs to access treatment for each joint deformity.

Item 50306 is amended to reflect modern clinical practice by updating the technique used for limb lengthening. A new item (50310) is listed to provide a Medicare benefit for major adjustments in a clinic setting that do not require anaesthetic, such as major strut changes.

*Paediatric – epiphysiodesis (growth plate) procedures*

Five (5) epiphysiodesis procedures (48500, 49503, 48506, 48509 and 48512) have been deleted or amended to limit the procedures from being claimed for patients over 18 years of age, per recommendation 164 of the Taskforce report. Items 48500, 48503 and 48506 are deleted and replaced with a new item (48507).



These items are for surgery to bone growth plates and aim to stop the growth of a long bone. The Taskforce agreed that when consumers reach skeletal maturity, they do not have growth plates. Allowing for variation between individuals, the vast majority of consumers will have reached skeletal maturity by 18 years of age.

#### *Paediatric fracture procedures*

Paediatric fracture procedures have been updated to modernise the MBS and ensure that items provide Medicare benefits for high-value services, per recommendations 165, 166 and 167 of the Taskforce report.

Four (4) paediatric fracture procedures (50508, 50512, 50532 and 50536) have been amended to consolidate similar services where differentiation between fractures is unnecessary, in an effort to streamline the MBS. Further changes will be made to items 50508 and 50512 to remove reference to terms specific to adult fractures.

Two (2) paediatric fracture items (50556 and 50564) have been amended to allow either an open or closed approach. These descriptors are updated to include the modern practice of closed reduction and percutaneous insertion of internal fixation. This surgical technique involves greater surgical time, skill, resources and clinical follow-up than closed reduction alone and will be incorporated into existing item numbers for open reduction of fractures. Two (2) new items (50592 and 50596) have been created for treatment of fracture of the shaft of the tibia or femur. These items were previously billed under equivalent adult items that do not properly capture the difficulty of the procedure in children with open growth plates.

#### **Consequential amendment to remove references to section 3F of the Act**

Section 3F of the Act has been repealed by Schedule 1 to the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020*. Clause 1.1.2 of the *Health Insurance (General Medical Services Table) Regulations (No. 2) 2020* had referenced vocationally registered general practitioners which is provided for under section 3F of the Act. The Regulations will discontinue references to section 3F in clause 1.1.2 to reflect the amendments made to the Act.

#### **Personal information and health assessment services**

Division 2.15 of Part 2 provides for the conduct of health assessments in relation to particular classes of people. Health assessments provide specific patient cohorts who have, or are at greater risk of developing, a chronic disease than the general population with an assessment of their health, physical, psychological and social function.

Health assessments, in their current form, have been available in the table made under section 4 of the Act since the 1 May 2010 commencement of the *Health Insurance (General Medical Services Table) Amendment Regulations 2010 (No. 3)*. The assessment allows GPs to assist patients with decisions on preventative health care and education to improve their overall health and wellbeing.

Like many other medical services, a health assessment requires the collection of sensitive information to enable GPs to make an informed decision of the patient's health and wellbeing.

Private sector health service providers (including individual and corporate GPs working in community practice) are subject to the *Privacy Act 1988* and, as APP entities under that Act, must not do any act, or engage in any practice, that breaches an Australian Privacy Principle. Recognising the sensitivity of health information, the Australian Privacy Principles give extra protection in relation to the handling of health information.

Health information that is collected, used or disclosed contrary to the Australian Privacy Principles constitutes an interference with the privacy of an individual. A person who is concerned their health information has been mishandled may lodge a complaint with the Office of the Australian Information Commissioner if they have been unable to resolve the dispute with the private sector health service provider. Serious or repeated interferences with privacy can be subject to a civil penalty of 2000 penalty units.

Private health sector service providers in the Australian Capital Territory, New South Wales and Victoria are also subject to state or territory legislation regarding health information. In addition, all medical practitioners have a professional responsibility to apply the ethical and professional conduct standards of the Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*. This includes protecting patients' privacy and right to confidentiality, unless release of information is required by law or by public-interest considerations.

The item descriptors for the health assessment items are not intended to create a stand-alone regime for the handling of personal information collected and recorded during those assessments. Rather, they set out what activities are required for a Medicare benefit to be payable for the service. So if, for example, the recipient of an older person's health assessment asks their GP for a record of the assessment to be provided to a family member who is not a carer, this is not intended to be prohibited by the instrument but the disclosure would be subject to normal requirements around the privacy of health information.

#### **Incorporation of documents by reference**

Paragraph 15J(2)(c) of the *Legislation Act 2003* provides that all documents referred to in instruments must be described, and an indication given as to how they can be obtained. The following documents have been incorporated by reference into the Regulations, and brief descriptions and access details follow.

- Health assessment incorporated documents (Group A14)

The following screening tools and clinical documents are relevant for the health assessment attendance items in Group A14.

The 'Australian Type 2 Diabetes Risk Assessment Tool' as defined in Part 7 of the Regulations. It is a tool developed by the Baker Heart and Diabetes Institute, as existing on 1 July 2020, to identify patients at high risk of type 2 diabetes. It can be viewed at [www.health.gov.au](http://www.health.gov.au).

The 'ADF Post-discharge GP Health Assessment Tool' as described in clause 2.15.10 of the Regulations. This document, as existing at 1 July 2020, is a post-discharge health assessment tool designed to assist GPs to identify and diagnose the early onset of physical and/or mental health problems among former serving Australian Defence Force members. It can be viewed at <http://at-ease.dva.gov.au>.

The 'Mental Health Advice Book' as described in clause 2.15.10 of the Regulations. This document can be used by GPs undertaking health assessments to assist them to deliver the most effective mental health treatments for former serving Australian Defence Force members. It can be viewed at <http://at-ease.dva.gov.au>.

- Geographical classifications

'ASGC', as defined in Part 7 of the Regulations, is the Australian Standard Geographical Classification. The July 2011 edition of the publication, as existing on 1 July 2020, can be

accessed at the Australian Bureau of Statistics' website at [https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Standard+Geographical+Classification+\(ASGC\)](https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Standard+Geographical+Classification+(ASGC)). It is used to determine eligibility for bulk billing item 10992.

'ASGS', as defined in Part 7 of the Regulations, is the Australian Statistical Geography Standard. The July 2016 edition of the publication, as existing on 1 July 2020, can be accessed at the Australian Bureau of Statistics' website at [https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Statistical+Geography+Standard+\(ASGS\)](https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Australian+Statistical+Geography+Standard+(ASGS)). The ASGS-RA structure is used as part of the determination of a Modified Monash area, per the definition in the Regulations.

'Regional, rural or remote area', as defined in Part 7 of the Regulations, is the Rural, Remote and Metropolitan Areas Classification. The document, as existing on 1 July 2020, sets out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994. RRMA may be accessed at the Department of Health's website at: <https://www.health.gov.au/health-workforce/health-workforce-classifications/rural-remote-and-metropolitan-area>.

'Telehealth eligible area', as defined in Part 7 of the Regulations, means an area classified as a telehealth eligible area by the Minister and identified on the Department's website on 1 July 2020. Telehealth eligible areas can be viewed at [www.health.gov.au](http://www.health.gov.au).

- NOSE scale

'NOSE scale', as defined in Part 7 of the Regulations, has the meaning given by clause 5.10.21. The Nasal Obstruction Symptom Evaluation Scale is an assessment tool developed by Stewart et al, as published in Otolaryngology-Head and Neck Surgery on 1 February 2004 (volume 130, issue 2). It may be accessed at <https://www.entnet.org/sites/default/files/NOSE-Instrument.pdf>

## Schedule 2 – Repeals

This section repeals the *Health Insurance (General Medical Services Table) Regulations (No. 2) 2020*.

## Statement of Compatibility with Human Rights

*Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011*

### ***Health Insurance (General Medical Services Table) Regulations 2021***

This Regulation is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

#### **Overview of the Disallowable Legislative Instrument**

The purpose of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) is to implement annual Medicare indexation and the Government's response to recommendations from the MBS Review Taskforce (the Taskforce) relating to general surgery and orthopaedic services.

The schedule fees of GP and specialist attendances, diagnostic investigations, and therapeutic and procedural items are increased by 0.9 per cent. This reflects the Government's policy regarding Medicare indexation and means that patients will receive an increased Medicare benefit for these services.

The Government's response to the Taskforce recommendations on general surgery will restructure the existing items to reflect contemporary practice, incentivise best clinical practice, and combine like procedures and clarify the requirements of ambiguous services to simplify the arrangements for doctors and patients. The changes will introduce 35 new items, amend 50 items and delete 71 items relating to laparoscopies and laparotomies, small bowel resections, abdominal wall hernia repairs, oncology and bariatric services, surgical excisions, and procedures relating to the oesophageal, stomach, liver, biliary, pancreas, spleen and lymph nodes.

The Government's response to the Taskforce recommendations on orthopaedic services will restructure the existing items to reflect contemporary practice, ensure services are clinically appropriate and improve quality of care and safety for patients. The changes will introduce 167 new items, amend 284 items and delete 143 items relating to orthopaedic services affecting the knee, hand and wrist, shoulder and elbow, hip, foot and ankle.

#### **Human rights implications**

The Regulations engage Articles 9 and 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), specifically the rights to health and social security.

##### *The Right to Health*

The right to the enjoyment of the highest attainable standard of physical and mental health is contained in Article 12(1) of the ICESCR. The UN Committee on Economic Social and Cultural Rights (the Committee) has stated that the right to health is not a right for each individual to be healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The Committee reports that the *'highest attainable standard of health'* takes into account the country's available resources. This right may be understood as a right of access to a variety of public health and health care facilities, goods, services, programs, and conditions necessary for the realisation of the highest attainable standard of health.

#### *The Right to Social Security*

The right to social security is contained in Article 9 of the ICESCR. It requires that a country must, within its maximum available resources, ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care. Countries are obliged to demonstrate that every effort has been made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, this minimum obligation.

The Committee reports that there is a strong presumption that retrogressive measures taken in relation to the right to social security are prohibited under ICESCR. In this context, a retrogressive measure would be one taken without adequate justification that had the effect of reducing existing levels of social security benefits, or of denying benefits to persons or groups previously entitled to them. However, it is legitimate for a Government to re-direct its limited resources in ways that it considers to be more effective at meeting the general health needs of all society, particularly the needs of the more disadvantaged members of society.

#### Analysis

For general surgery and orthopaedic services, the Regulations maintain existing rights to health and social security ensuring access to publicly-subsidised medical services which are clinically appropriate and reflective of modern clinical practice. For other medical services, the Regulations furthers the right to health and the right to social security by increasing the Medicare benefit for patients accessing these services. This will assist patients to continue accessing clinically relevant health services, consistent with the rights to health and social security.

#### **Conclusion**

This instrument is compatible with human rights because it maintains existing arrangements and the protection of human rights.

**Greg Hunt**

**Minister for Health and Aged Care**