Changes to MBS pain management items - additional information and responses to questions

Last updated: 12 April 2022

- From 1 March 2022, changes were made to a number of the Medicare Benefits Schedule (MBS) items for pain management services to align with contemporary best practice. The changes are a result of the MBS Review Taskforce recommendations for pain management and extensive consultation with stakeholders.
- Since then, some further regulatory changes have been made to the percutaneous neurotomy items 39110, 39111, 39116, 39117, 39118 and 39119 in response to feedback from stakeholders. These changes take effect on 11 April 2022 and are explained below.
- This factsheet also provides additional information on a range of other issues in response to questions from stakeholders. This information should be read in conjunction with other materials on the MBS Online website.
- Updated versions of the following factsheets are also available at: MBS online website - Pain Management Services Changes.
    - Nerve block and spinal injection items
    - Implanted device procedure items.

Changes to the percutaneous neurotomy items 39110, 39111, 39116, 39117, 39118 and 39119 – effective 11 April 2022

There are six MBS items applicable to percutaneous neurotomy (items 39110, 39111, 39116, 39117, 39118 and 39119). The items relate to six regions of the spine (lumbar, thoracic, and cervical divided into left and right sides). These items commenced on 1 March 2022.

Effective 11 April 2022, there are new frequency claiming restrictions for these items.

A patient can now receive percutaneous neurotomy treatment in up to three episodes of care in a 12-month period. An episode of care means one or more percutaneous neurotomy services performed in a single attendance, where clinically relevant.

The percutaneous neurotomy items are claimable per joint treated, not per nerve or lesion. For compliance purposes, practitioner should record the name of the joint/s that are being treated during an attendance in the patient's clinical notes.

More than one joint in the same region can be treated and claimed on the same day (i.e. as part of the same episode), and joints in another region can also be treated in the same episode.

The Multiple Operation Rule will continue to apply when more than one joint is being treated in the same episode.

The 12-month period is a rolling period, commencing on the date of the first episode (for treatment provided on or after 11 April 2022), to a maximum of three episodes over the next 12 months. For example, if the first episode of treatment is provided on 20 April 2022, up to two further episodes of treatment can be provided up to 19 April 2023.

Treatment provided under these items from 1 March 2022 to 10 April 2022 (inclusive) will not be counted in the 12-month period for the patient.

Responses to questions about billing the percutaneous neurotomy items

Would treatment of the T12/L1 zygapophyseal joint be classified as a thoracic procedure or a lumbar procedure?

Treatment of the T12/L1 zygapophyseal joint should be classified as a thoracic region procedure. Accordingly, the thoracic items 39116 or 39117 would be appropriate for such a procedure.

Would treatment of the C7/T1 zygapophyseal joint be considered cervical (39118/39119) or thoracic (39116/39117)?

The C7/T1 facet joint is innervated by the medial branches of C7 and C8 (cervical region). Accordingly, the relevant cervical items 39118 or 39119 would be appropriate for such a procedure.

How can I check if my patient has already received 3 episodes of joint denervation treatment services?

Practitioners should first discuss what treatment has been provided over the last 12 months with the patient.

A patient (or a provider if the patient is present and able to provide consent) can access information on their claiming history by calling the Medicare General Enquiries line on 132 011. Patients can also access their own claiming history with a My Health Record, or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Is the injection of cortisone and local anaesthetic included in the percutaneous neurotomy items?

The intent of these items is that they represent a complete medical service. If the administration of either the anaesthesia or corticosteroid is an integral component of the procedure, then under the complete medical service principle, additional items should not be billed for these services (see Explanatory Notes GN.14.34 and TN.10.7).

Responses to questions about percutaneous denervation item 39323

When will the '6 times a year per nerve' restriction start for this item?

Item 39323 is limited to 6 times a year per nerve. The 12-month period will start from the first time the item has been claimed on or after 1 March 2022 and will continue on a rolling 12-month basis.

For compliance purposes, the applicable nerve treated must be documented in the patient record and noted on Medicare claims for item 39323, for example, '39323 - Right Genicular nerve'.

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MBS changes factsheet

Responses to questions about billing for Percutaneous Electrical Nerve Stimulation (PENS) procedures?

Can I bill an MBS item for a Percutaneous Electrical Nerve Stimulation (PENS) procedure?

No. The use of PENS for the management of chronic pain has not been assessed by the Medical Services Advisory Committee (MSAC) or recommended for public funding. Therefore, PENS procedures for management of chronic pain cannot be billed under the MBS, including items 39129 and 39138.

MSAC appraises new medical services proposed for public funding and provides advice to Government on whether a new medical service should be publicly funded (and if so, its circumstances) on an assessment of its comparative safety, clinical effectiveness, cost-effectiveness, and total cost, using the best available evidence. Further information is available at www.msac.gov.au.

Responses to questions about epidural or peripheral nerve lead items (39129, 39130, 39136, 39137, 39138, 39139)

Can I bill item 39138 (surgical placement of peripheral nerve leads) for trial procedures?

Item 39138 was amended on 1 March 2022 to incorporate the wording ‘where the leads are intended to remain in situ long term’. Item 39138 will continue to be the appropriate item to bill when lead placement is required for a spinal cord stimulator trial prior to longer term placement, when the leads are surgically placed.

Item 39129 will be the appropriate item to bill for the placement of leads including trial procedures, when the leads are percutaneously placed.

Can I bill these items more than once for a single episode of care?

The billing arrangements for items 39129, 39130, 39136, 39137, 39138, 39139 can continue to be claimed more than once for a single episode of care where clinically appropriate. The Multiple Operation Rule will continue to apply to these items. There is no intention to change current billing practices for these items, e.g. where more than one lead may be billed as part of an episode.

Questions about the nerve block item restriction with T8 surgical procedures (18228, 18238, 18244, 18252, 18254, 18262, 18264, 18266, 18280, 18288, 18278, 18234, 18236)

What is the meaning of “not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach”?

From 1 March 2022, a new restriction has been introduced which blocks the co-claiming of items 18228, 18238, 18244, 18252, 18254, 18262, 18264, 18266, 18280, 18288, 18278, 18234, 18236 with any MBS item in Group T8 (Surgical Operations). The only exception to the restriction is when a targeted percutaneous approach is used.

A targeted percutaneous approach is when the nerve block is performed via the skin using a technique aimed directly at the nerve, i.e. not distributed in the area (not a field infiltrative technique).

If a block has been performed using a targeted percutaneous approach, this must be noted on the Medicare claim with text 'targeted percutaneous approach' or 'TPA'.

If I have performed a nerve block using a 'targeted mucous membrane approach', will I be able to claim the nerve block item? (i.e. a vermilionectomy (item 45669) performed with a nerve block (18234))

For the purposes of these items, a clinically appropriate nerve block performed using a targeted mucous membrane approach will meet the requirement of a targeted percutaneous approach.

Does this restriction exclude the injection of cortisone and local anaesthetic injected via the RF probe port (commonly performed with Radio Frequency denervation procedures)?

The intent of the T8 surgical procedures is that they represent a complete medical service. If the administration of either the anaesthesia or corticosteroid would be considered as an integral component of the procedure, then under the complete medical service principle, additional items should not be billed for these services (see Explanatory Notes GN.14.34 and TN.10.7).

Where can I find more information?

The current pain management item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au.

You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health provides an email advice service for providers seeking advice on interpretation of MBS items and rules and the Health Insurance Act and associated regulations. If you have a question regarding the interpretation of the pain management items, please email askMBS@health.gov.au.

For questions regarding the private health insurance classifications, please email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors will be available via the MBS Online website under the Downloads page.

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 above and does not account for MBS changes since that date.