WORKERS COMPENSATION
(ORTHOPAEDIC SURGEON FEES) ORDER 2021

under the

Workers Compensation Act 1987

I, Carmel Donnelly, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 25th day of November 2020

Carmel Donnelly
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is an Orthopaedic Surgeon is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for treatment by an Orthopaedic Surgeon provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent an Orthopaedic Surgeon from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

Treatment by a Surgeon other than an Orthopaedic Surgeon is covered by the *Workers Compensation (Surgeon Fees) Order 2021.* However, maximum fees under this Order may apply to procedures carried out by a Surgeon which are covered by the *Workers Compensation (Surgeon Fees) Order 2021.*

Orthopaedic Surgeons should also refer to the *Workers Compensation (Medical Practitioner Fees) Order 2021.*

This Order adopts the items listed as Orthopaedic Procedures in the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA).

To bill an AMA item number an Orthopaedic Surgeon must be confident they have fulfilled the service requirements as specified in the item descriptor.

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each item fully meets the item descriptor. Where an operation comprises a

combination of procedures which are commonly performed together, and for which there is an AMA item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item number is used, separate items must not be claimed for any of the individual items included in the comprehensive service. The invoice should cover the total episode of treatment.

The incorrect use of any items referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Workers Compensation (Orthopaedic Surgeon Fees) Order 2021

1. Name of Order

This Order is the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2021*.

2. Commencement

This Order commences on 1 January 2021.

3. Definitions

In this Order (including Schedules A, B, C and D):

the Act means the *Workers Compensation Act 1987*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

Assistance at Operation means a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medicare Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 to MY330 and MZ731 to MZ871. Assistance at Operation is only payable once per eligible item number performed by the principal Orthopaedic Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation. Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon), using the AMA item code MZ900.

Note: Assistance at Operation fees are not payable to health practitioners who are not a Medical Practitioner eg. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No:** PD2019_027), Assistance at Operation fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant Assistant at Operation fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The

Authority reserves the right to conduct an audit of Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

AMA List means the document entitled List of Medical Services and Fees issued by the Australian Medical Association and dated 1 November 2020 and any subsequent amendments to this List published by the AMA in the period 1 November 2020 – 31 October 2021.

Compound (open) wound refers to a situation where an Orthopaedic Surgeon is treating a fracture and the injury is associated with a compound (open) wound. In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.

Extended initial consultation means a consultation involving significant multiple trauma or complex "red flag" spinal conditions (systemic pathology, carcinoma, infection, fracture or nerve impingement) involving a lengthy consultation and extensive physical examination.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Initial consultation and report covers the first consultation, the report to the referring Medical Practitioner and the copy of the report to the insurer.

The report will contain:

- the worker's diagnosis and present condition;
- an outline of the mechanism of injury;
- the worker's capacity for work;
- the need for treatment or additional rehabilitation; and
- medical co-morbidities that are likely to impact on the management of the worker's condition (in accordance with privacy considerations).

The receipt of this report and any certificates of capacity under section 44B of the Act post-treatment will provide sufficient information for insurers, employers and workplace rehabilitation providers to develop recovery at/return to work plans.

Insurer means the employer's workers compensation insurer

Instrument fee covers procedures where the Orthopaedic Surgeon supplies all the equipment or a substantial number of specialised instruments in exceptional circumstances and must be justified. This fee does not apply for all operations or if only incidental instruments (non-critical) are supplied by the Orthopaedic Surgeon. Routine items such as loupes are not included.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in this Order prevent combining of items. The fee for the main procedure or injury is to be paid in full as per Schedule A (1.5 x AMA List fee), and for each additional item or injury at 1.125 x AMA List Fee specified in Schedule A.

Opinion on file request includes retrieval of a file from whatever source, reading time, and reporting where a request for such an opinion has been made in writing to the Orthopaedic Surgeon and in accordance with privacy principles.

Orthopaedic procedures are those listed in the AMA List but do not include the cost of bandages, dressings, plaster of Paris bandages, splints, metallic fixation agents, and prosthetic implants which may be charged in addition to the fee set out in Schedules in this Order, if purchased by the Orthopaedic Surgeon. The fee for Orthopaedic procedures includes pre-surgery consultations conducted on the same day of surgery and aftercare visits.

Orthopaedic Surgeon means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist in orthopaedic surgery and who is registered with the Australian Health Practitioner Regulation Agency as a Specialist in surgery, in the field of orthopaedic surgery. It includes an Orthopaedic Surgeon who is a staff member at a public hospital providing services at the hospital.

Out-of-hours consultation means a call-out to a public or private hospital or a private home for an urgent case before 8.00am or after 6:00pm Monday to Friday, or anytime on the weekend and public holidays. This fee is not to be utilised where a consultation is conducted for non-urgent cases.

Out-of-hours loading only applies when an Orthopaedic Surgeon is called back to perform a procedure(s) in isolation, rather than for cases scheduled before 8.00am or after 6.00pm on a weekday or a routine weekend operating list. Loading to be calculated at 20% of the total procedure fee. Item must be reflected in the invoice as a separate entry against code WCO008.

Revision surgery refers to a procedure carried out to correct earlier surgery. Only where the revision surgery is performed by an Orthopaedic Surgeon other than the original Orthopaedic Surgeon, shall it attract a fee of 50% of the amount for the principal procedure in the initial surgery, in addition to the fee payable for the new procedure. Where the new procedure is specified as a revision procedure in the AMA List, the 50% loading does not apply.

Spinal surgical rules and conditions provided in the current Medicare Benefits Schedule apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171) conducted on or after 1 January 2021.

Subsequent consultation and report is each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the Orthopaedic procedure**.**

The subsequent Orthopaedic Surgeon consultation fee includes a subsequent consultation, a report from the subsequent consultation to the referring General Practitioner and copy of the report to the insurer. Providing copies of these reports does not attract a fee.

Telehealth means delivery of consultations via video or telephone by an Orthopaedic Surgeon. Consultations would be inclusive of any electronic communication to support the delivery of the service. Orthopaedic Surgeons must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes are not compromised. Telehealth consultations must be consented to by the worker. Orthopaedic Surgeons are responsible for delivering Telehealth consultations in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure the safety, appropriateness and effectiveness of the service. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of the *Workers Compensation (Medical Practitioner Fees) Order 2021)*. Orthopaedic Surgeons are to bill for Telehealth consultations using the same AMA Fees List item number normally billed for a face to face consultation, with the addition of a 'T' as a suffix to the item number e.g. AC510T (Subsequent consultation and report delivered via telehealth) versus AC510 (Subsequent consultation and report delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for treatment by Orthopaedic Surgeon

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by an Orthopaedic Surgeon, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 3 of that Schedule.

A fee charged by an Orthopaedic Surgeon for a patient's treatment (including the management of fractures and other conditions) will be in addition to the fee in Schedule A for the initial consultation and report.

6. Billing items for hand surgery (Schedule B)

Schedule B provides mandatory guidelines for billing items used in hand and wrist surgery only.

Table 1 details items that are not billable for hand surgery procedures.

Table 2 details items with restricted application for hand surgery and where clinical justification is required that they are reasonably necessary given the circumstances of the case.

7. Billing items for shoulder and elbow surgery (Schedule C)

Schedule C provides mandatory guidelines for billing items used in shoulder and elbow surgery only.

Any item number where the term “flag” is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

8. Billing items for general upper limb surgery (Schedule D)

Schedule D provides mandatory guidelines for billing items used in general upper limb surgery.

Any item number where the term “flag” is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

9. GST

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Medical Practitioner or an Orthopaedic Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority’s itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website at www.sira.nsw.gov.au.

All invoices with surgical items must also be accompanied by the following:

(1) Detailed operation report including a description of the initial injury and an outline of the mechanism of injury, time surgery commenced and finished, intra-operative findings and the procedures performed, including structures that were repaired (stating the anatomic location) and technique of repair.

(2) Usage of any of the restricted item numbers (Schedule B, Table 2, Schedule C and Schedule D) must be accompanied by clinical justification in order to process the claim.

Note: A Medical Practitioner who provides Assistance at Operation is to invoice for their services separately to the principal Orthopaedic Surgeon/Medical Practitioner.

11. Surgery requests

For any proposed surgery – a list of proposed applicable AMA item numbers will need to be provided prior to approval being given.

Where questions arise in individual clinical situations, supply of additional information may be required to assist in determinations.

12. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

13. Nil payment for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with an Orthopaedic Surgeon.

SCHEDULE A
MAXIMUM FEES FOR ORTHOPAEDIC SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report (AC500T to be utilised when consultation delivered via telehealth)	AC500/AC500T (MBS 104)	$340.40
2.	Extended initial consultation and report	WCO006	$468.90
3.	Subsequent consultation and report (AC510T to be utilised when consultation delivered via telehealth)	AC510/AC510T (MBS 105)	$234.50
4.	Out-of-hours consultation	WCO007	$196.70 in addition to consultation fee
Procedures			
5.	Orthopaedic procedure(s)	ML005 (MBS 46300) to MY330 (MBS 50239) and MZ731 (MBS 50950) to MZ871 (MBS 51171)	1.5 x AMA List Fee for the primary item number. (For any additional item numbers refer to item 8 of this Schedule).
6.	Instrument fee	WCO003	$234.50
7.	Assistance at Operation (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners eg. perioperative nurses). Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon). Note: Assistance at Operation is only payable once per eligible item number performed by the principal Orthopaedic Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation.	MZ900	A fee of 20% of the Orthopaedic Surgeon's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS, or $393.20, whichever is the greater.

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
8.	Multiple operations or injuries		Primary item number to be paid in full (1.5 x AMA List Fee) and additional AMA item number(s) at 1.125 x AMA List Fee.
9.	Aftercare visits (As defined in this Order)		As per AMA List
10.	Compound (open) wound		In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.
11.	Out of hours loading	WCO008	20% of total procedure fee
Insurer/lawyer requests			
12.	Opinion on file request	WCO009	$234.50
13.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order 2021)* or where there is a request to provide medical records and the Medical Practitioner needs to review the records prior to provision (to redact non work-related injury information)	WCO002	$45.30 per 5 minutes
14.	Lost reports and reprints		$158.90 per report
15.	Consulting Orthopaedic Surgeon reports (where additional information that is not related to the routine injury management of the patient is requested by either party to a potential or current dispute)	Relevant IMS/WIS code	Please refer to the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2020* No.2 Schedule 2

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
	Note: The party requesting a report must agree on the category of report with the Medical Practitioner in advance and confirm the request in writing at the time of referral.		
16.	Fees for providing copies of clinical notes and records	WCO005	Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Consulting Orthopaedic Surgeon's notes and reports) is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a Medical Practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified at item 13, Schedule A. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

SCHEDULE B

BILLING ITEMS USED IN HAND SURGERY

Table 1: Items numbers and descriptors not applicable to hand surgery procedures

AMA/MBS item number	Descriptor	Reason for decline
CV233/18266 CV082/Nil	INJECTION OF AN ANAESTHETIC AGENT, ulnar, radial or median nerve of main trunk, one or more of, not being associated with a brachial plexus block MINOR NERVE BLOCK (specify type) to provide post-operative pain relief (this does not include subcutaneous infiltration)	The MBS does not allow a claim for nerve blocks performed as a method of postoperative analgesia. Infiltration is included in both the anaesthetic schedule AND in the surgical item number fee if performed by the Orthopaedic Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Orthopaedic Surgeon as the only form of anaesthesia and no charge is raised for another anaesthetic service.
MG540/45051	CONTOUR RECONSTRUCTION for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Surgical Operations; (b) injection of liquid or semisolid material; and (c) services to insert mesh	This relates to the insertion of foreign implant for pathological deformity by an open operation i.e. facial reconstruction and was not intended for usage in hand surgery.
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	TENDON, repair of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR210/47966	TENDON OR LIGAMENT TRANSFER, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR220/47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MR230/47972	TENDON SHEATH, open operation for tenovaginitis, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS015/48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.

AMA/MBS item number	Descriptor	Reason for decline
MY015/50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY025/50104	JOINT, synovectomy of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY045/50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MY105/50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
OF820/60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service to which another item in this table applies (R)	This item cannot be billed for use of image intensification when operated by the Orthopaedic Surgeon in the absence of a radiographer.
OF824/60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R)	This item cannot be billed for use of image intensification when operated by the Orthopaedic Surgeon in the absence of a radiographer.

Table 2: Item numbers with restricted application for hand surgery – clinical justification required

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105 Note: If consultation is undertaken via telehealth, code AC510T applies	Each attendance SUBSEQUENT to the first in a single course of treatment	Follow up consultations will not be paid within the 6-week period following a procedure as this is included in normal aftercare.
EA075/30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.)	The repair of wound must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. Item EA075/30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not billable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures. Debridements are also not billable when removing percutaneous wire fixation. This item can be billed for deep chronic wounds or in combination with open fractures requiring debridement. This item is not to be billed in combination with EA215/30068. Limit of one debridement per episode of care or per limb. This item cannot be billed when a surgeon applies the 50% loading for open fracture fixation. Flag if this procedure is requested more than once per episode of care or per limb.
EA095/30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7CM IN LENGTH), involving deeper tissue, not being a service to which another item in Group 3.4 applies.	This item is for use in wound suture when no other vital tissue is involved. It cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury, nor when repair of a performed and deeper structure is also claimed for.
EA755/30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS OR SIMILAR LESION, requiring admission to hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare)	This item cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury.
EA825/30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE	This item is rarely indicated and cannot be billed in conjunction with: items EA075/30023 MR240/47975, MR250/47978, MR260/47981

AMA/MBS item number	Descriptor	Clinical indication
ET560/33815 ET570/33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques	This item is never indicated in acute trauma. It is rarely indicated in elective surgery and is reserved for use in revision nerve decompression surgery. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament), by open procedure, unless for a revision procedure.
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques	This item can only be billed once per named nerve trunk, regardless of the number and distal distribution of individual cables. This item cannot be billed in conjunction with items LN790, LN800 or LN810
LN760/39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques	This item cannot be billed in conjunction with items LN790, LN800 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324 LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation	This item cannot be billed in conjunction with item LN810.
LN810/39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item LN740 applies	This item is not for the identification of nerves during surgical exposure. It is not to be billed in combination with item LN700. This item is not to be billed in conjunction with item MU400: Wrist carpal tunnel release (division of transverse carpal ligament) by open procedure. However, items LN810 and MU400 can be billed together for combined open carpal tunnel release and cubital tunnel release surgery. This item is not to be billed in conjunction with item ML235 Tendon sheath of hand/wrist open operation for stenosing tenovaginitis.
MH115/45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, and excluding flap for male pattern baldness and excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084	This item is rarely indicated in the hand and wrist as a large defect will not be readily amenable to a local flap reconstruction. It is not to be billed for suturing of traumatic skin flaps.
MH125/45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excluding H-flap or double advancement flap,	This item can only be billed once for a z-plasty.

AMA/MBS item number	Descriptor	Clinical indication
	not in association with any of items EN036 to EN084	
MJ025/45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit	This item relates to microvascular repair of an artery or vein. This item cannot be billed for repair of dorsal veins with volar skin intact, branches of digital arteries, branches of radial/ulnar vessels and venae comitantes of major arteries. Microvascular repairs distal to the metacarpophalangeal joint will also require clinical documentation of appropriate surgical technique utilising an operating microscope.
MJ030/45501 MJ035/45502	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit/ MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit	These items specifically relate to replantation of limb and digit. i.e. the amputated portion must be completely detached.
MJ045/45503	MICRO-ARTERIAL or MICRO-VENOUS graft using microsurgical techniques	This item includes the remuneration for harvesting the graft and performing any microvascular anastomoses to the graft.
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty	This item cannot be billed in conjunction with other items e.g. nerve repair, tendon repair, flap repair (i.e. intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.
ML105/46325	CARPAL BONE replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML115/46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of	This item is not to be billed in addition to item EA075/30023 when arthrotomy is performed to facilitate joint lavage within an open wound.

AMA/MBS item number	Descriptor	Clinical indication
ML125/46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.
ML135/46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of using free tissue graft or implant	This item is only billable for repair of named ligaments using free grafts or alloplast where preoperative or intraoperative findings document significant joint instability. This item cannot be billed for reattachment of ligament using a bone anchor. Item ML125/46330 is the approved number.
ML145/46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint	This item cannot be billed in conjunction with any other item or procedure related to the joint. This item cannot be billed in conjunction with item EA075/30023.
ML155/46339	EXTENSOR tendons or FLEXOR tendons of hand or wrist synovectomy of	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML235/46363). Note: If performing a complete flexor tenosynovectomy, a release of the Carpal Tunnel is part of the operation and therefore MU400 or MU410 should not be billed. If this item is requested in conjunction with MU400 or MU410 (Wrist carpal tunnel release) or ML235/46363 (De Quervain's), clinical documentation of gross synovitis is required, preferably with histological confirmation. Flag if this procedure is requested two or more times.
ML185/46348 – ML225/46360	Digit, synovectomy of flexor tendon or tendons	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with ML155/46339
ML235/46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis	This item is not to be billed in combination with LN810/39330. Item used for De Quervain's Release or Trigger Finger Release. De Quervain's tenosynovitis - can only be billed once per side (ie: includes both APL and EPB tendons).
ML245 – ML335 / 46366 – 46393	Dupuytren's contracture, fasciotomy	Flag if this procedure is requested for an acute injury or trauma
ML345/46396	PHALANX or METACARPAL of the hand, osteotomy or osteectomy of	This item is applicable for removing excess bone formation in an *intact* bone. This is no longer to be applied to removal of loose pieces of bone in trauma or bone shortening for terminalisation or replantation. This is part of the debridement and is included in item EA075/30023 if applicable.

AMA/MBS item number	Descriptor	Clinical indication
		This item is not to be billed in combination with MR130/47933 or MR140/47936. Flag if this procedure is requested for an acute injury or trauma.
ML405/46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF in preparation for tendon grafting	Tenolysis (items ML545/46453, ML535/ 46450) or tenotomy (item MR200/47963) of the tendon to be grafted cannot be billed with this item.
ML425/46420	Extensor tendon of hand or wrist, primary repair, each tendon	For an acutely injured tendon as a primary procedure. This item should not be billed for repair of extensor tendon split as part of an access to phalangeal fractures/osteotomies.
ML445/46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon	Not to be billed more than once to repair FDS tendon in a digit. This item can only be billed a maximum of twice per digit.
ML465/46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML475/46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon	This item is not to be billed in acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450 ML545/46453	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft	These items are applicable for freeing tendons from scar following previous surgery or trauma. They are not indicated in an acute hand injury. Items ML545 and ML535 cannot be billed in conjunction with release of trigger finger or for release of DeQuervians' (see ML235/46363).
ML695/46494	Ganglion of Hand, excision of	Not being a service associated with a service to which another item in this Group applies.
ML705/46495	Ganglion or mucous cyst of distal digit, excision of	Not being a service associated with a service to which item EA355/30107 applies.
ML715/46498	Ganglion of flexor tendon sheath, excision of	Not being a service associated with a service to which item EA355/30107 applies.
ML725/46500	Ganglion of dorsal wrist joint (excision)	This item is not to be billed in combination with EA355/30107.
ML735/46501	Ganglion of volar wrist joint (excision)	This item is not to be billed in combination with EA355/30107.
ML745/46502	Recurrent ganglion of dorsal wrist joint (excision)	This item is not to be billed in combination with EA355/30107.
ML755/46503	Recurrent ganglion of volar wrist joint (excision)	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation	These items are only to be billed for a heterodigital neurovascular island flap used to

AMA/MBS item number	Descriptor	Clinical indication
		resurface pulp loss (e.g. Littler flap, first dorsal metacarpal artery or Kite flap). There is a limit of one flap per digit. Flag if this procedure is requested two or more times.
ML795/46513	Digital nail of finger or thumb, removal of	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489). This item is not to be billed in combination with ML805/46516.
ML805/46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day hospital facility	This item is not to be billed in association with primary or secondary nail bed repair (items ML665/46486, ML675/46489). This item is not to be billed in combination with ML795/46513.
ML825/46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB - open operation and drainage for infection	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury.
ML835/46525	Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital,	Not being a service to which another item in this Group applies (excluding after-care).
MR088/47920	BONE GROWTH STIMULATOR, insertion of	This is only billable where a mechanical bone growth stimulator has been inserted. It is not for the insertion of OP1 or other bone morphogenic proteins in the setting of hand surgery.
MR090/47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure	This item cannot be billed when the k-wire has been used as part of fracture fixation. Can be billed for the insertion of a temporary pin in association with a ligament/tendon repair.
MR110/47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day hospital facility - per bone	This item applies for removal of *buried* k-wire. Where a k-wire or wires cross more than 2 bones, only 1 item number is billable.
MR630/48239 MR640/47306	BONE GRAFT (with or without internal fixation), not being a service to which another item in this Group applies	These items cannot be billed in conjunction with fracture fixation numbers or the following items: ML005/46300, ML015/46303, ML355/46399, ML365/46402, ML375/46405, MR560/48218 - MR620/48236.
MS005/48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of,	Excluding services to which items MX660 or MX670 applies. This item is only applicable to sesamoidectomy.
MS015/48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation	Excluding services to which items MR130/47933 or MR140/47936 apply.
MS025/48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion),	This item <u>is</u> the appropriate number for excision of the pisiform. This item is <u>not</u>

AMA/MBS item number	Descriptor	Clinical indication
	RIB, TARSUS OR CARPUS, osteotomy or osteectomy of	appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by open (MU400) or endoscopic (MU410) approach	These are the appropriate item numbers for a primary carpal tunnel release. Ultrasound costs are not billable in conjunction with this surgery procedure. Nerve Conduction Studies (NCS) preferable prior to surgical consideration, other than in acute cases. This item is rarely indicated in combination with ML155/46339: Extensor tendons or flexor tendons of hand or wrist (synovectomy of). MU400 and MU410 cannot be billed with ML155/46339 – Billing is only approved for one OR the other of these codes. Flag if this code combination is billed.
MU460/49209	Wrist, total replacement arthroplasty of	Flag if this procedure is requested.
MU462/49210	Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis	Flag if this procedure is requested.
MU464/49211	Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis	Flag if this procedure is requested.
MU470/49212	WRIST, arthrotomy of	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500; ML735/46501; ML475/46502; ML755/46503)
MU480/49215	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy	Including repair of single or multiple ligaments or capsules, including associated arthrotomy. Can be used in combination with MR210/47966 for chronic scapholunate repair where the original ligament is not repairable or ML415/46417.
MU490/49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Wrist, Arthroscopic surgery of wrist	Involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area. Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy	Not being a service associated with any other arthroscopic procedure of the wrist.
MU520/49227	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption	Not being a service associated with any other arthroscopic procedure of the wrist joint.

AMA/MBS item number	Descriptor	Clinical indication
MY035/50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this group applies	This item is applicable for stabilization of CMC joints only.

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (November 2017)* with minor modifications. Relevant items from the *WorkCover Queensland Upper Limb Surgery* Guidelines are provided within Schedule C and their use is mandatory when billing for shoulder and elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
BONE GRAFTS		
MR550/48215	Humerus, bone graft to, with internal fixation	
MR640/48242	Bone graft, with internal fixation	Not being a service to which another item in this group applies.
MS005/48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of,	Excluding services to which item MX660/49848 or MX670/49851 applies, any of items MX660/49848, MX670/49851, MR130/47933 or MR140 apply.
MS025/48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of	Excluding services to which items MR130/47933 or MR140/47936 apply. Not to be billed in combination with item MT770/48951. May be billed with MY035/50106 if excision of the distal clavicle is done in conjunction with the stabilisation – eg: Weaver Dunn Procedure. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960)**
MS035/48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, with internal fixation	Excluding services to which items MR130/47933 or MR140/47936 apply. May be billed with MY035/50106 if the coracoclavicular ligaments are reconstructed in the same procedure. Not to be billed in combination with item MT770/48951. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**

AMA/MBS item number	Descriptor	Clinical indication
MS045/48412	HUMERUS, osteotomy or osteectomy of,	Excluding services to which items MR130/47933 or MR140/47936 apply. Can be billed with item MR020/47903 (tennis elbow release) if a lateral or medial epicondylectomy is performed. Can be billed with LN810/39330 if ulna nerve neuritis or compression has been diagnosed requiring formal surgical decompression.
SHOULDERS		
MT600/48900	Excision or coraco-acromial ligament or removal of calcium deposit from cuff or both	Open operation not arthroscopic. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is used twice or more.**
MT610/48903	Decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any other combination	Open operation, also known as open acromioplasty or subacromial decompression (SAD).
MT620/48906	Repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff or both	Known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. If MS025 is performed it cannot be billed with item MT770. Can be billed in combination with arthroscopic code MT770/48951 (and MR210/47966 if a bicep tenodesis is performed). Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	Repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coroco-acromial ligament and distal clavicle, or any combination	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Flag if this item is billed with item MX670/49851.** Not to be billed with MT770/48951 or in combination with MT610/48903. This item is not to be billed with services associated with any other **arthroscopic** procedure of the shoulder region.
MT640/48912	Shoulder arthrotomy	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed in combination with any other item code for shoulder surgery.**
MT650/48915	Hemi-arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.

AMA/MBS item number	Descriptor	Clinical indication
MT660/48918	Total replacement arthroplasty including rotator cuff repair	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	Revision of total replacement arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total replacement arthroplasty with bone graft to scapula or humerus	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Removal of shoulder prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT700/48930	Stabilisation for recurrent anterior/posterior dislocation	Known as open shoulder stabilisation (including repair of labrum). If recurrent, treatment option: highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition.
MT710/48933	Stabilisation for multidirectional instability	Mostly used for open procedures.
MT720/48936	Synovectomy as an independent procedure	Use of this item rarely seen in State Insurance Regulatory Authority claims **Flag if this item is billed in combination with any other item code**
MT730/48939	Arthrodesis with synovectomy	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis with synovectomy, removal of prosthesis and bone grafting	Use of this item rarely seen in State Insurance Regulatory Authority claims **Flag if this item is billed once or more**
MT750/48945	Diagnostic arthroscopy	Not to be billed with any **arthroscopic** procedure of the shoulder region. May be billed with open surgery i.e. items MT630/48909, MT620/48906, MT710/48933.
MT760/48948	Arthroscopic surgery, with one or more: removal loose bodies, decompression of calcium deposits, debridement labrum/synovium/rotator cuff, chondroplasty	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Preparatory for an open procedure. Appropriate with items MT620/48906 and MT630/48909. May be billed with items MT700/48930 and MT710/48933.
MT770/48951	Arthroscopic division of the coraco-acromial ligament including acromioplasty	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with items EA365/30111 or MT780/48954. Can be billed in combination with MT620/48906 when performing an open rotator cuff repair (and MR210/47966 if a biceps tenodesis is performed).

AMA/MBS item number	Descriptor	Clinical indication
MT780/48954	Arthroscopic total synovectomy including release of contracture (shoulder)	Known as frozen shoulder release; stand-alone item code. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT770/48951. **Flag if this item is used with any other item for shoulder surgery.**
MT790/48957	Arthroscopic stabilisation for recurrent instability including labral tear or reattachment	Not to be billed with any other **arthroscopic** procedure of the shoulder region. If recurrent treatment option, highly recommend looking into claimant's history to determine if surgery is to treat the aggravation or pre-existing condition. **Flag if this item billed with any other item for shoulder surgery.**
MT800/48960	Reconstruction or repair of, including rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach	Not to be billed with any other procedure of the shoulder region. May be billed with item CV218/18256. Not to be billed with item **EA365/30111, MT770/48951 OR MT790/48957.** May be billed in combination with MR210/47966 or MR200/47963. **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of Nerve	Not appropriate for use in epicondylitis surgery – refer to item LN810/39330 (this item applies to transposition of ulna nerve anterior to medial epicondyle to submuscular or subcutaneous site). Not to be combined with MS045/48412 or LN810/39330.
MU035/49100	Arthrotomy of, involving one or more of lavage, removal of loose body or division of contracture	Not to be billed for tennis elbow surgery.
MU045/49103	Ligamentous stabilisation	Not to be billed in conjunction with item LN810/39330 unless the ulnar nerve requires mobilisation or decompression at the time of stabilisation (operation notes should reflect this). Transposition item LN770/39321 is commonly used. Ulnar nerve transposition can occur frequently in large elbow operations. It may be necessary to perform neurolysis of more than one nerve such as radial and ulnar, if there was significant previous injury or previous surgery.
MU055/49106	Arthrodesis with synovectomy	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**

AMA/MBS item number	Descriptor	Clinical indication
MU065/49109	Total synovectomy	Known as **common contracture release.** Use of this item rarely seen in State Insurance Regulatory Authority claims. May be appropriate with osteotomy i.e. items MS045/48412 or MS025/48406. **Flag if billed.**
MU075/49112	Silastic replacement of radial head	Seen with fractures, dislocations and acute trauma. May be associated with other items i.e. MU045/49103 or MU075/49121. Not to be billed in combination with item MU065/49109**.** **Flag if billed.**
MU085/49115	Total joint replacement	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	Total replacement arthroplasty, revision procedure, including removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU087/49117	Total replacement arthroplasty, revision procedure with bone grafting or removal or prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU095/49118	Diagnostic arthroscopy	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Arthroscopic surgery of elbow involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty	Not to be billed with any other **arthroscopic** procedure of the elbow.
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of	May be billed in combination with olecranon bursa. **Flag if billed in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960.
LN810/39330	Neurolysis by open operation without transposition	Not being a service associated with a service to which item LN740/39312 applies. Can be billed in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be billed in combination with item MT760/48948. **Flag if billed in combination with any item codes for shoulder surgery or in acute trauma.**

AMA/MBS item number	Descriptor	Clinical indication
LIMB LENGTHENING AND DEFORMITY CORRECTION		
MZ330/50405	Elbow, flexorplasty, or tendon transfer to restore elbow function	MR170/47954 is the appropriate code for repair of a distal bicep tendon rupture. Use of this item rarely seen in State Insurance Regulatory Authority claims – set of item numbers address congenital conditions. **Flag if billed.**
OTHER JOINTS		
MY035/50106	Joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation	Not being a service to which another item in this group applies – stand-alone item. May be billed with MS025/48406 if excision of the distal clavicle is used in conjunction with the stabilisation – e.g. Weaver Dunn procedure. Flag if requested in combination with MR210/47966, MS025/48406 or MS035/48409.
MY055/50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue,	Not being a service to which another item in this group applies. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT780/48954. **Flag if billed in combination with any item code for elbow and shoulder surgery.** Implies a release for stiffness after injury or surgery. May occur with other numbers in relation to a large release of a stiff elbow. Three to five item numbers should be in association with an operation that took two to three hours and is usually a revision situation or after serious trauma. The complexity should be reflected in the history of injury, number of prior operations, duration of surgery, complexity of the operation note.
MY065/50115	Joint or joints, manipulation of, performed in the operating theatre of a hospital	Code used for adhesive capsulitis (frozen shoulder) manipulation under anaesthetic (MAU). Not to be billed for an 'examination' of a joint under general anaesthetic prior to an operation, where the general anaesthetic is for the operation itself. Not being a service associated with a service to which another item in this group applies. **Flag if this item is billed two or more times.**
MY105/50127	Joint or joints, arthroplasty of, by any technique	Not being a service to which another item applies. Not to be billed in combination with any item for shoulder, elbow or sternoclavicular surgery.

AMA/MBS item number	Descriptor	Clinical indication
GENERAL		
MP455/47429	Humerus, proximal, treatment of fracture of, by open reduction	
MP465/47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction	
MP485/47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction	
MP495/47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction	
MR020/47903	Epicondylitis, open operation for	This is the only item number appropriate for Tennis or Golfers Elbow Debridement (Lateral or Medial Epicondylitis). Can be combined with MS045/48412 where a formal excision of the epicondyle is justified, not just for debridement of epicondyle. Can also be combined with LN810/39330 if ulna nerve neuritis or compression has been diagnosed which requires formal surgical decompression. **Flag if billed in combination with any other item numbers.**
MR100/47924	Buried wire, pin or screw (1 or more inserted for internal fixation purposes), removal of requiring incision and suture – per bone.	Not being a service to which item MR410/47927 or MR120/47930 applies.
MR110/47927	Buried wire, pin or screw, one or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital	This item applies for removal of one or more buried k-wire per bone. Where fixation crosses two or more bones, only one item number is billable.
MR120/47930	Plate, rod or nail and associated wires, pins or screws, one or more of, all of which were inserted for internal fixation purposes, removal of	Not being a service associated with a service to which items MR100/47924 or MR110/47927 apply - per bone. Where fixation crosses two or more bones, only one item number is claimable.
MR170/47954	Tendon, repair of, as an independent procedure	Can be billed in treating biceps tenodesis. Can be billed in treating distal biceps tendon rupture (Refer to item MR210/47966 for proximal biceps tenodesis). **Flag if billed with any other item code.**
MR190/47960	Tenotomy, subcutaneous	Not being a service to which another item in this group applies.

AMA/MBS item number	Descriptor	Clinical indication
MR200/47963	Tenotomy, open, with or without tenoplasty	Not being a service to which another item in this group applies. Not to be billed for epicondylitis/tennis elbow release." Could be billed in combination with items MT770/48951 or MT800/48960.
MR210/47966	Tendon or ligament, transfer	As an independent procedure Could be billed in combination with items MT770/48951 or MT800/48960
MR220/47969	Tenosynovectomy	Not being a service to which another item in this group applies. Should not be billed for tennis elbow or shoulder surgery. **Flag if billed for shoulder or elbow procedures.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (November 2017) with minor modifications* . The relevant items from the *WorkCover Queensland Upper Limb Surgery Guidelines* are provided in Schedule D and their use is mandatory when billing for upper limb surgery.

AMA/MBS item number	Descriptor	Clinical indication
EA080 – EA155 / 30024 - 30049	Repair of Wounds	The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. The term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.
EA355/30107	Ganglion or small bursa, excision of	Not being a service associated with a service to which another item in this Group applies.
MN020 – MN160/ 47003 - 47045	Treatment of upper limb dislocations	Check AMA Fees List for item descriptions and exclusions of item combinations.
MS055/48415	Humerus, osteotomy or osteectomy, with internal fixation	Excluding services to which items MR130/47933 or MR140/47936 apply. Not to be billed with item LN810/47903 (tennis elbow release) unless a lateral epicondylectomy is performed. Flag if this item is requested, particularly if requested for tennis elbow surgery.
MY005/50100	Joint, diagnostic arthroscopy of (including biopsy)	Not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure.
MY010/50102	Joint, arthroscopic surgery of	Not being a service to which another item in this Group applies.