



Co-claiming restrictions on MBS items 30621, 48406, and 48409

Date of change: 1 November 2025

Amended items: 30621, 48406 and 48409.

Last updated – 13 October 2025

Revised structure

- From 1 November 2025, Medicare Benefit Schedule (MBS) items 30621, 48406, and 48409 will be amended to prevent co-claiming with 25 cardiothoracic procedural items.
- The changes are supported by the Australian and New Zealand Society of Cardiac and Thoracic Surgeons and will prevent inappropriate co-claiming to ensure the MBS is sustainable.
- Providers were inappropriately claiming additional Medicare benefits for component parts of the procedure when the primary cardiothoracic items provided the full benefit for all components as a complete service.

Patient impacts

These changes will ensure Medicare benefits are paid appropriately to patients.

Restrictions or requirements

“Other than a service to which item XYZ applies” refers to a restriction preventing the payment of a benefit when the service is performed in association (on the same occasion) with a specific MBS item or item range, another MBS item within the same group or subgroup or a similar type of service or procedure.

MBS items 30621, 48406, and 48409 can no longer be co-claimed with item 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764.

Providers should be aware that if a co-claiming restriction is detailed in the item descriptor, a successful payment of the restricted co-claim items by Services Australia does not automatically make the co-claiming valid. Providers would be subject to post-payment audit based on the restrictions detailed in the item descriptor.

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the Department of Health, Disability and Ageing's compliance program can be found on its website at [Medicare compliance](#).

Amended item 30621 (to take effect 1 November 2025)

Category 3: Therapeutic procedures

Group: T8 – Surgical operations

Subgroup: 1 - General

30621

Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30651, 30655, 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies (H)

(Anaes.) (Assist.)

[Multiple Operation Rule](#)

Fee: \$475.40 Benefit: 75% = \$356.55

- Private Health Insurance Classification: Type A Surgical
- Clinical category: Digestive system
- Procedure type: In hospital

Amended item 48406

Category 3: Therapeutic procedures

Group: T8 – Surgical operations

Subgroup: 15 - Orthopaedic

Subheading: 5 - Osteotomy And Osteectomy

48406

Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed):

Category 3: Therapeutic procedures

- (a) removal of bone;
- (b) excision of surrounding osteophytes;
- (c) synovectomy;
- (d) joint release;

other than a service to which item 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies—one bone (H)

(Anaes.) (Assist.)

[Multiple Operation Rule](#)

Fee: \$384.45 Benefit: 75% = \$288.35

(See para [TN.8.168](#), [TN.8.190](#), [TN.8.196](#), [TN.8.200](#) of explanatory notes to this Category)

- Private Health Insurance Classification: Type A Surgical
- Clinical category: Bone, joint and muscle
- Procedure type: In hospital

Amended item 48409

Category 3: Therapeutic procedures

Group: T8 – Surgical operations

Subgroup: 15 - Orthopaedic

Subheading: 5 - Osteotomy And Osteectomy

48409

Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed):

- (a) removal of bone;
- (b) excision of surrounding osteophytes;
- (c) synovectomy;
- (d) joint release;

other than a service to which item 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies—one bone (H)

(Anaes.) (Assist.)

Category 3: Therapeutic procedures

[Multiple Operation Rule](#)

Fee: \$604.05 Benefit: 75% = \$453.05

(See para [TN.8.168](#), [TN.8.190](#), [TN.8.196](#), [TN.8.200](#) of explanatory notes to this Category)

- Private Health Insurance Classification: Type A Surgical
- Clinical category: Bone, joint and muscle
- Procedure type: In hospital

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.