



## MBS Cardiac Services Webinar Questions

Last updated: 6 November 2020

- This change is effective from 1 August 2020.
- A factsheet summarising what the changes are, why the changes have been made, how it will affect stakeholders and what they need to do is available on MBS Online.
- The webinar recording is now available on the Department of Health’s [Website](#).
- If you cannot find the information you need, please contact the Department of Health at [askMBS@health.gov.au](mailto:askMBS@health.gov.au) or [cardiacservices@health.gov.au](mailto:cardiacservices@health.gov.au).
- To subscribe to future MBS Online updates, visit [www.mbsonline.gov.au](http://www.mbsonline.gov.au) and click ‘subscribe’.

### Contents

Electrocardiography.....	2
Ambulatory electrocardiography.....	4
Echocardiography (general) .....	5
Plain echocardiography .....	7
Stress echocardiography.....	9
Myocardial perfusion studies/nuclear medicine.....	11
Paediatric/fetal .....	12
Other.....	13



## Electrocardiography

**Q1. Item 11705 (twelve-lead ECG, report only where the tracing has been forwarded to a specialist or consultant physician) is claimable for private admitted patients. Do descriptors F and G prohibit use for cardiologists if they have any financial interest or attend a patient on a ward round?**

The purpose of (f) is to stop the practice of one provider in a group practice referring to colleagues in the same practice for a report (where there is a shared financial incentive for both the requestor and the reporting provider).

- (f) A service in item 11705 does not apply if requesting practitioner has a financial relationship with the medical practitioner who renders the service.

The purpose of (g) is to highlight that this is a request for a report only. However an allowance has been made for the scenario where in a hospital, the reporting cardiologist that has been requested to complete a report may also be required to consult (only cardiologist available) as a result of the ECG outcome for the purposes of urgent care.

- (g) A service in item 11705 does not apply if the service is performed on the same day as the day on which an attendance is performed on the patient by the medical practitioner.

**Q2. Is item 11705 (twelve-lead ECG, report only where the tracing has been forwarded to a specialist or consultant physician) only eligible if a formal referral is provided?**

Yes, a written request is required.

**Q3. Which medical practitioners will be able to claim ECG items that include reporting from 1 August 2020?**

From 1 August 2020, only specialists and consultant physicians will be able to claim items that include reporting. All other medical practitioners will only be able to claim item 11707 (tracing only).

**Q4. Can a post-operative ECG be claimed if the patient's condition deteriorates?**

Yes, but only for report item 11705 (specialist or consultant physician). The trace conducted by the requesting (treating medical practitioner) or private hospital staff (e.g. nurse) will no longer attract an MBS fee/rebate. However, a request can be made for a formal report (item 11705) as mentioned above.

**Q5. Is there an MBS rebate for inpatient ECG services? If not, will there be funding for hospitals to continue these services?**

There is no MBS rebate for inpatient ECG services. A formal report by a specialist or consultant physician (item 11705) on a trace provided by the requesting medical practitioner can be claimed if the patient is an admitted patient of a hospital.



The MBS works as a fee for service model and does not provide for individual commercial contractual agreements between private entities. Funding of other plain ECG services for an admitted patient will be considered to be a part of standard private insurance accommodation and procedural funding by the insurer.

## **Q6. Can GP's refer twelve-lead ECGs and Holter monitors?**

A GP can request (but not claim) the following items:

1. Item 11704 (Twelve-lead electrocardiography, tracing and report)
2. Item 11705 (Twelve-lead electrocardiography, report only where the tracing has been forwarded to a specialist or consultant physician, not in association with a consultation on the same occasion)
3. Item 11707 (trace only) GP can request and claim.
4. Item 11714 (Twelve-lead ECG, performing a trace and interpretation)
  - In practice this would also be accompanied by a referral for the specialist or consultant physician to provide a consultation.

In relation to Holter monitors:

1. A GP can request items 11716, 11717 and 11723 (AECG)

## **Q7. Will the changes reduce the number of ECG and ambulatory ECG items that GP's are able to request?**

For ECG, the net result will be an increase in the number of ECG items that a GP can request.

For ambulatory ECG, four of the current ambulatory ECG items will be deleted from the MBS schedule from 1 August 2020 due to obsolescence. These items will be replaced with three new items. Services that are conducted under the current schedule items are expected to be captured across the three new ambulatory ECG items.

## **Q8. Why are there separate exercise ECG testing items for over 17 years and under 17 years?**

There are slightly different indications and requirements for adult patient testing compared to paediatric patient testing.

When a paediatric cardiologist conducts this type of service, there are no restrictions on claiming a consultation with the service. This is a claiming system requirement.

## **Q9. Why is a chronotropic response to exercise not an indication for an ECG exercise stress test?**

This could potentially exclude a patient from the service as they may not present with an elevated heart rate.

However, further information and context is needed to provide a comprehensive answer to this question.



**Q10. Is item 11705 claimable by a reporting consultant or physician if the requesting specialist (i.e. orthopaedic specialist) has seen the patient on that day?**

Yes, item 11705 is claimable.

**Q11. Is it correct that patients cannot have an ECG as part of their pre-operative assessment?**

No. A hospital that conducts a pre-operative assessment can still conduct an ECG as a part of the assessment.

However, this service will no longer attract a MBS rebate. Pre-operative ECG's are considered to be part of the standard private insurance accommodation and procedural funding by the insurer.

**Q12. For item 11714, is a separate report still required? There was a mention that as long as the ECG was described in the letter that this would be sufficient?**

For ECG item 11714, the written clinical note detailing the interpretation of the ECG can be incorporated into the letter back to the requesting practitioner if required, this clinical note is expected to detail more than the just the trace measurements or the diagnoses automatically generated from the trace. It is expected that the interpretation would comment on the clinical significance of the trace and the relationship between this and the clinical decisions made for the patient.

## Ambulatory electrocardiography

**Q13. What is the rationale for replacing implanted ECG loop recording item 11722 with item 11731?**

The Taskforce recommendation for this item required a new four week claiming restriction. Therefore, a new item number has been applied to reflect this.

**Q14. For item 11729 (multi-channel ECG monitoring and recording during exercise), could the wording be changed to health practitioner with cardiopulmonary resuscitation (CPR) training such as a Registered Nurse?**

This has been changed in the final descriptors and regulation and will be a person trained in exercise testing and CPR. This provides some flexibility to suit practices of varying sizes.

**Q15. Can item 11716 be requested by a GP?**

Yes, item 11716 can be requested by a GP but can only be claimed by a specialist or consultant physician.

**Q16. Can item 11731 be claimed when the loop recorder is interrogated but the patient is not present?**

Currently, the requirement of this item is for an in-clinic review, with a formal report produced as part of the service and provided to the patient and referrer.



**Q17. Is the implanted loop recorder a four-weekly in-clinic review or a four-weekly remote review?**

Currently, the requirement of this item is for an in-clinic review, with a formal report produced as part of the service and provided to the patient and referrer.

## Echocardiography (general)

**Q18. How can providers review images of an echo prior to a procedure or surgery if they are unable to get the images from another provider? Can the provider re-image the patient?**

No, the patient cannot be re-imaged.

It would be expected that the echo images would be sourced by the patient from the provider who provided the echo service or the provider who is to undertake the procedure would source the images prior to the procedure.

If an echo had been completed within 24 months of the planned procedure (items 55141, 55145 or 55146) then a repeat echo can only be claimed under item 55143 when:

- the patient has symptoms of ischaemia that have evolved and are not adequately controlled with optimal medical therapy.

**Q19. Are there item numbers for contrast echocardiography?**

There is no specific item number for contrast echocardiography. The Cardiac Services Clinical Committee did not identify a requirement for this type of echocardiography service.

**Q20. Transplant patients currently get a transthoracic echo one year and a stress echo the alternate year to avoid an angiogram. Would this work with repeat tests under the new item numbers?**

Yes, there are no cross over restrictions regarding time intervals between plain echo and stress echo. As an example:

- 1) 1 August 2020 plain echo
- 2) 1 August 2021 stress echo
- 3) 1 August 2022 plain echo
- 4) 1 August 2023 stress echo

This regime would also adhere to the 24-month restriction for a stress echo.



**Q21. What constitutes an echo? Is there a distinction between focused studies (15 minutes) and full studies (45-60 minutes, >70 captured images)?**

This is defined in the requirements for each view/anatomical area (e.g. assessment of left and right atrial structures including quantification of atrial sizes) that must be assessed for a full study compared to a focused study.

It is not based on time as it would be expected that experienced providers may be able to complete all the requirements of each study in a shorter time period.

**Q22. Is the multiple services rule only for echo items?**

The new echocardiography multiple service rule only applies to the new subgroup 7. This new subgroup only contains the new plain echo and stress echo items.

**Q23. There were some echo items claimable by GPs. This is not safe without adequate echo training. Please explain the rationale behind this.**

GPs cannot claim any echocardiography items. There are restrictions as to who can request certain echocardiography items. Only specialists or consultant physicians can claim echocardiography items.

**Q24. How are we to investigate patients who develop recurrent or more worrying symptoms within the two year window?**

The initial echocardiogram (55126) has a two-year restriction, as the entry point for investigating cardiac symptoms. Once specific indications are diagnosed then repeat studies can be performed as clinically required, meeting the requirements of the descriptor and requested by the specialist or consultant physician.

Echo item 55134 gives specialists / consultant physicians access to a repeat scan item for rare cases where the indications are not met in the other repeat items (55127, 55128, 55132, 55133 or 55137).

A stress echo can be repeated within the 24-month period by a specialist or consultant physician. If a patient had evolving or recurrent symptoms, it would be expected that the patient would be under the care of a specialist or consultant physician.



## Plain echocardiography

**Q25. Is there a time restriction to serial echo's under item 55129? For example, if a patient has an echo one month prior but was then admitted to hospital with heart failure.**

No, however a provider is expected to adhere to the Cardiac Society of Australia and New Zealand (CSANZ) guidelines for heart failure monitoring which will be detailed in the explanatory note.

**Q26. Will there be an online portal to identify if a patient has used item 55126 in the last two years?**

Yes. The existing Health Professional Online Services (HPOS) online portal provides an instant response on previous claims. E.g. enter item 55126 into HPOS and you will be notified if this item has been claimed in the previous 2 years.

**Please note** that claiming is prospective from 1 August 2020. If an existing plain echo item has been claimed in the two years prior to 1 August 2020 (e.g. 55113), the provider will not be blocked from claiming 55126.

Further details on HPOS can be found at:

[www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/hpos](http://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/hpos)

**Q27. How often do you expect item 55134 (repeat real time echocardiographic examination of the heart) to be used?**

It would be expected that this would constitute less than 10% of a providers plain echo claims unless they specialise in rare presentations.

This item will be monitored closely for appropriate use.

**Q28. Will all items for the transthoracic echo start on 1 August 2020? Additionally, if an echo is booked for 1 August 2020, can item 55126 be claimed initially even if an echo may have been done earlier (e.g. for pulmonary hypertension)?**

Yes. All the new transthoracic echo items will commence 1 August 2020.

The new time restrictions are prospective, so the items that exist prior to 1 August 2020 have no effect on the new items going forward. E.g. Item 55126 can be claimed for all patients who require (and meet the criteria) for an initial echo from 1 August 2020.

**Q29. What item should a radiology practice use if they have already used item 55126 and the patient is referred to a cardiologist or hospital and a full comprehensive study is required due to poor quality on the previous report?**

If a provider undertakes a plain echo service and the quality of the study is considered inadequate, then the provider should complete the service to a level that is acceptable before claiming the item.



If another study was required, a repeat study can be undertaken using item 55134. Item 55134 is expected to make up a very small percentage of a provider's claiming and usage will be monitored by the Department of Health.

If a patient has a previous diagnosis for e.g. structural heart disease or primary valvular dysfunction, then a provider can use the corresponding repeat items for a complete study.

### ***Q30. Can a specialist self-refer for items 55127 and 55129 (plain echo)?***

Yes, items 55127 (echo for known valvular dysfunction) and 55129 (echo for known heart failure) are requested services which can be requested by the specialist performing the test.

### ***Q31. Do the time restrictions for items 55126, 55127 and 55129 (once every two years) apply to different specialists?***

The time restrictions for claiming item 55126 apply to all specialists and consultant physicians, there are no time restrictions for items 55127 and 55129 (but it is expected that providers would follow the Cardiac Society of Australia and New Zealand [CSANZ] guidelines for management as per the explanatory notes).

- Echocardiogram item 55126 should be used as the entry point for adult patients, providing a baseline initial echocardiographic examination.
- Although this item can be requested by a medical practitioner, it can only be claimed by a specialist or consultant physician.
- A service under item 55126 is restricted to two years. If more frequent echocardiograms are required then services can be claimed under the item for that specific indication, such as item 55127 for patients with known valvular dysfunction, or 55129 for patients with known heart failure or structural heart disease.
- If item 55127 or 55129 have been performed then item 55126 cannot be claimed for 2 years.

### ***Q32. Is there a limit of frequency for items 55127 and 55129?***

Although echocardiogram items 55127 and 55129 do not have time or frequency restrictions as they are performed based on clinical need – specific clinical indications must be met prior to claiming these repeat studies and should be conducted at the time intervals from the referenced guidelines in the explanatory notes (unless there is a significant deterioration in the patient's symptoms).

### ***Q33. Can an initial echo (item 55126) be claimed on a separate day to a stress echo (item 55141)?***

Yes. Item 55126 can be claimed on a separate day to stress echo item 55141, provided other criteria are met for one or more of the indications in the descriptors. It would be preferred that patients were not required to travel for tests





more than required, therefore if a patient requires both studies, then the provider should make every reasonable attempt to conduct both studies on the same day.

**Q34. *Is pulmonary hypertension monitoring an indication for echocardiography?***

In initial echocardiogram item 55126, pulmonary hypertension is listed as an indication for performing this test. Repeat investigations can be requested by a specialist or consultant physician using item 55129.

**Q35. *If a patient is referred from a GP in a Modified Monash Model (MMM) 5 area and the test is done in a MMM 1 area, does the item number refer to where the test is done or where the referral came from?***

Echo item 55128 for repeat echocardiography for valvular dysfunction gives medical practitioners in a MMM 3-7 area access to request this scan. The MMM location of the GP or the GP's practice requesting the item must be within the 3-7 area to meet the requirements of the item. The patient can have the test performed in any MMM location.

**Q36. *Scenario: A patient was last seen 18 months ago and had an echo for shortness of breath but had no structural abnormality to follow up from. However, they have now had an acute myocardial infarction. When is it reasonable to use item 55129?***

If a confirmed acute myocardial infarction has occurred it would be reasonable that a provider would suspect some structural effect on the heart. It would therefore be reasonable to use item 55129 for a repeat study in this scenario.

However, if no structural abnormality was found then it would be considered inappropriate to continue claiming item 55129 for further follow-up.

## Stress echocardiography

**Q37. *Has there been consideration for billing yearly stress tests or stress echo for licensing requirements? E.g. commercial truck drivers, pilots, trotter drivers and trainers over 70 years of age?***

The cardiac imaging MBS items are not claimable for the purposes of occupational screening. This applies to the current schedule items and will also apply to the new items.

**Q38. *Why is having indeterminate lesions on computed tomography coronary angiography (CTCA) an indication for stress echo? Shouldn't a stress echo/stress test should be done first as per the guidelines?***

This provides for instances including the following where:



- CTCA was completed prior and there was a significant lesion or lesions detected without reported signs or symptoms. This allows an assessment to ascertain if the lesion is of functional significance.
- Invasive coronary angiography (ICA) is conducted for one territory e.g. left anterior descending (LAD) artery that leads to stenting and at that time a 50% lesion is evident in the left circumflex artery. This lesion should not be stented, but would be suitable for a stress echo assessment of functional significance.

### **Q39. What if an exercise ECG is equivocal and an exercise stress echo is needed?**

If an exercise ECG test is equivocal and the patient's signs or symptoms warrant further investigation, then a stress echo can be requested if the patient meets the indications for stress echo.

### **Q40. A very high coronary calcium score suggests high risk for stenosis. How is this covered for under stress echo?**

This is covered by indication c) (iii): coronary artery disease related lesions, of uncertain functional significance, which have previously been identified on computed tomography coronary angiography or invasive coronary angiography.

### **Q41. Can you please explain the difference between these three scenarios:**

- 1. A 65 year old patient with hypertension, smoking, hypercholesterolaemia, insulin requiring type 2 diabetes mellitus and having non-cardiac surgery can have a stress echo for pre-operative assessment.**
- 2. A 65 year old patient with hypertension, smoking, hypercholesterolaemia, oral hypoglycaemic diabetes mellitus and having non-cardiac surgery cannot have a stress echo for a pre-operative assessment.**
- 3. A 65 year old patient with hypertension, smoking, hypercholesterolaemia and having non-cardiac surgery cannot have a stress echo for pre-operative assessment.**

A patient with insulin dependent Type 2 diabetes would in most circumstances be considered higher risk and further progressed in the disease process (with associated complications) than those requiring oral management.

It would be expected that for a patient with a functional capacity of less than four metabolic equivalents (confirming intermediate or high risk for surgery), it would be unlikely that they would not qualify under one or more of the indications for pre-operative assessment for cardiac or non-cardiac surgical intervention.

### **Q42. Are there any provisions under stress echo to check for inducible arrhythmias? E.g. ventricular tachycardia (VT)**

It would be expected that exercise ECG stress testing (EST) would be undertaken initially for the purpose of inducing arrhythmias e.g. VT; or



Indication (vii) can be used as highlighted in yellow if EST is unsuccessful at inducing an arrhythmia that the provider suspects is present.

(vii) for patients where silent myocardial ischaemia is suspected or due to the patient's cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

### ***Q43. Why can't physicians bill for consultations with stress tests and stress echo?***

The MBS Review Taskforce identified two scenarios whereby a patient may be sent for a stress test or stress echo:

1. GP request for a specialist or consultant physician to conduct the study only. In this scenario it should not be assumed that a consultation is required (particularly if the result of the stress echo study does not require clinical decision/input by the specialist at the time of conducting the study), with the recommendation from MBS Review Taskforce confirming that a consult should not be claimed.
2. GP refers the patient to the specialist or consultant physician for a consultation; and
  - requests that the stress echo is conducted also; or
  - where an attendance service is conducted at the conclusion of the echo service where clinical management decisions are made as a result of the echo service outcome; or
  - the decision is made during the attendance that a study (e.g. stress echo) is required.

## Myocardial perfusion studies/nuclear medicine

### ***Q44. Should the indications for a GP referred MPS study be known prior to the appointment and stated on the referral? Or can it be investigated on a patient's arrival with consultation and noted on referral?***

Yes. The clinical assessment by the GP should identify one or more of the indications from the descriptor for GP requested MPS and this should be listed on the request.

### ***Q45. Item 61325 does not reflect the cost of the thallous chloride. The tracer costs \$460, prior to staff and equipment costs. Will this fee be re-examined?***

Not at this time. The clinical experts on the Implementation Liaison Group for Cardiac Services (including a cardiac nuclear medicine specialist) did not recommend an increased fee for thallous chloride, noting that this item can be claimed twice to reflect the need for a second scan in a 24-hour period (redistribution).



**Q46. In regards to nuclear medicine MPS item changes, some have reference to Tc99m and Tl-201 but some don't reference the radiopharmaceutical. In these items i.e. 61324 that do not reference the radiopharmaceutical, is there a restriction?**

A myocardial perfusion study is claimable once every two years. This consists of either one combined study or one rest study together with one stress study. The single rest study using the thallous chloride-201 protocol requires a second scan within a 24-hour period. Hence, a separate item was introduced to allow for the claiming of both scans but only one claim for the technetium protocol under item 61321.

The radioisotope is only referenced in the two single rest items because one is allowed to be claimed once in a 24-month period (technetium) and one is allowed to be claimed twice in a 24-month period (thallium).

## Paediatric/fetal

**Q47. Does the new fetal echo item cover a screening fetal echo in high risk pregnancies (e.g. previous child or parental coronary heart disease, multiple fetal abnormalities and others in line with international guidelines?)**

Yes, if the requesting specialist or consultant physician suspects there may be a congenital heart defect, they can request this service and the service will be claimable by the (providing) paediatric cardiologist (with advanced training in cardiac fetal imaging).

**Q48. We often see patients who are under 17 years of age. I am not a paediatric cardiologist, can I still claim a consult?**

Yes, as long as the conditions for claiming a consultation are met (Item 11730).

**Q49. Can an adult cardiologist seeing a 16 year old patient without a history of coronary heart disease bill item 55132 for an echo to assess for structural heart disease?**

No, they cannot bill item 55132.

**Q50. Can an adult cardiologist claim for an echo done on a person under 17 years of age?**

Item 55126 can be claimed for any person of any age by any cardiologist (except fetal).

It would be expected that if a person under 17 years requires repeat echo studies they would be referred to a paediatric cardiologist for future review and studies. These follow-up studies would be completed under item 55132.



**Q51. I am in a rural area and we have a visiting paediatric cardiologist every two months. I am not a paediatric cardiologist but I offer a bridging service during the gaps in visits. If there are any abnormalities I contact them immediately. What should we do in the future?**

Without knowing all the relevant details of your situation and what item changes you are referring to specially, it is difficult to provide an answer to your question. The Department would appreciate more details regarding this question.

However, 55132 should be claimed by a paediatric cardiologist practising in their specialty. Those who are not a sub-specialist in paediatric cardiology can claim the other related items however, any paediatric claiming will be monitored closely by the Department of Health's compliance area.

## Other

**Q52. How do we define adult congenital specialist for reporting?**

Adult congenital heart disease specialists are not currently recognised by the Medical Board of Australia. This type of provider would be easily identified within the profession and would be expected to be claimed by a small number of providers. If the Department of Health identified unusual claiming patterns within the associated item then compliance activity would be undertaken.

**Q53. Do time restrictions commence as of 1 August 2020 for repeat studies?**

All of the 1 August 2020 new item restrictions are prospective. Therefore, you will have to have had an initial study after 1 August 2020 before you can then claim a repeat item.

**Q54. We have patients from rural and remote areas who have a test on the same day they see us, is this allowed?**

Yes, but only under the following circumstances:

- (1) Items 11716, 11717, 11723 or 11729 do not apply to a service unless:
  - (a) the patient is referred to a specialist or consultant physician by a referring practitioner; or
  - (b) the service is requested by a requesting practitioner.
- (2) For referred services to which items 11716, 11717, 11723 or 11729 apply, the specialist or consultant physician who renders the service must:
  - (a) manage the ongoing care of the patient; or
  - (b) perform an attendance to determine that testing is necessary, where the need for the test has not otherwise been scheduled; or



- (c) perform an attendance immediately after the test has been performed, at which clinical management decisions are discussed with the patient.
- (3) For any particular patient, a service associated with an attendance item listed in Part 2 of the general medical services table does not apply if a service to which item 55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145 or 55146 applies is provided on the same day; unless:
- (a) the consultation service is provided after the service where clinical management decisions are made;  
or
  - (b) the decision to perform the service on the same day was made during the consultation service subject to clinical assessment.
- (4) For any particular patient, a service associated with an attendance item listed in Part 2 of the general medical services table does not apply if a service to which item 61321, 61324, 61325, 61329, 61345, 61349 or 61357 applies is provided in the same day; unless:
- (a) the consultation service is provided after the service where clinical management decisions are made;  
or
  - (b) the decision to perform the service on the same day was made during the consultation service subject to clinical assessment.

***Q55. Will there be training for GPs and specialists for checking a patient's eligibility before referring?***

Services Australia has various training resources available for the Health Professional Online Services (HPOS) online portal where item eligibility can be checked instantly. This can usually be undertaken by administration staff on behalf of the provider.

***Q56. Are co-claiming restrictions only for the same day? What happens if a study is done the day before or after?***

The new multiple service rule for plain echo and stress echo only applies on the same day.

A plain echo can be conducted and claimed one day and then a stress echo can be conducted and a claimed on another day with no restriction.

However, if a decision is made in the same consultation where both are required then acceptable practice would be to provide both services the same day (for patient convenience).



For example, if a GP refers to a specialist for both services it is not acceptable to schedule the two services on separate days unless it is urgent.

***Q57. Is there a possibility for further consultation with the sector?***

The review of the cardiac services has been extensive, beginning in April 2016, with the MBS Review Taskforce recommendations being finalised in August 2018. The Department has worked closely with a number of key stakeholders to discuss and seek advice on the implementation of the cardiac items. This has been achieved through the Implementation Liaison Group process, meetings with the sector and individual clinicians.

Following the implementation of the 1 August 2020 cardiac imaging changes, the Department will continue to engage with the sector and consider all the feedback received encourage further feedback for future policy development.

***Q58. In the webinar, did 'eligible requestor' mean claiming? Rather than a referral for a procedure?***

Eligible requestor means the provider can request the service.

***Q59. Why are there differences between items for rural and metropolitan GP's?***

The Cardiac Services Clinical Committee identified patient access issues to cardiology specialists in rural and remote areas and that there was a need for GP's in those geographical locations to be able to refer for appropriate primary valvular dysfunction monitoring.

***Q60. How will the MBS determine if a same day attendance is done in the same group practice?***

This would involve a post-payment audit of a provider and can be identified based on the address attached to an individual's provider number.

***Q61. Items for exercise ECG testing, stress echo and stress MPS (nuclear medicine) state that a second medical practitioner trained in exercise testing who is immediately available for an emergency call is required. Does the second person need to be a doctor?***

Exercise ECG testing, stress echo and stress MPS (nuclear medicine) will require that a person trained in cardiopulmonary resuscitation (CPR) must directly supervise the patient during a stress test and a medical practitioner must be immediately available during the entire test. This in effect means that two CPR trained persons are immediately available to manage the patient with one person required to be a medical practitioner.

***Q62. The requirement for a second doctor to be immediately available would render many private practices with a single doctor on site unable to do the stress tests. What avenues are available to ensure that these practices are exempted from this requirement?***

The regulation requires that a second person trained in exercise testing and cardiopulmonary resuscitation is located at the premise while the testing is being performed and be available if required, this could be a nurse or nuclear



technician for example. Either the person performing the test or the second person must be a medical practitioner (e.g., single medical practitioner is immediately available. This requirement is important for maintaining optimal patient safety).

***Q63. If a patient has no symptoms and has occult silent severe ischaemic heart disease and we cannot do tests and the patient dies from sudden death, what are the legal implications?***

The appropriate test for a patient is always at the discretion of the treating provider. However, the test will only attract and MBS rebate if criteria for the item has been met.

It is acknowledged that some patients have silent myocardial ischaemia and where this is suspected a stress echo can be performed see below:

- for patients where silent myocardial ischaemia is suspected, or due to the patient's cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

***Q64. If the original plan was to hold this seminar/webinar three months before implementation, why is this now being implemented in August 2020 and not October 2020?***

Due to the impact of the COVID-19 pandemic the implementation timelines for many MBS changes have been impacted, this includes the cardiac items. We recognise the significant impact that COVID-19 has had on the sector, and we appreciate the challenges that might arise with the 1 August 2020 timeframe, however this is a measure that the Government has prioritised. Any further delay may impact on the ability to implement other important MBS Review changes.

***Q65. Will there be audits for appropriate use of item numbers?***

Certain items where the Taskforce has noted unexpected claiming patterns and volumes will be monitored by the Department.

***Q66. Will there be some guidance by Medicare for submitting claims in the initial stages?***

Please contact Services Australia and/or Ask MBS for further information on submitting claims.

***Q67. Will there be a probation period for submitting the new item numbers?***

The new items will commence on 1 August 2020, the deleted items will no longer be claimable from 1 August 2020.

***Q68. Will there be an education program for GPs regarding changes?***

The Department is listening to feedback and in response to the sector is producing a Quick Reference Guide for GPs to assist with understanding the changes.





**Q69. When will the detailed item descriptors for each of the 29 items be available in their full form?**

The items have been finalised and the legislation is now available.

The [Health Insurance \(Section 3C General Medical Services – Cardiac Services\) Determination 2020](#) for General Medical Services Table (GMST) items can be found at: <https://www.legislation.gov.au/Details/F2020L00917>.

The [Health Insurance \(Section 3C Diagnostic Imaging Services – Cardiac Services\) Determination 2020](#) for the Diagnostic Imaging Services Table (DIST) items can be found at: <https://www.legislation.gov.au/Details/F2020L00918>.

The Quick Reference Guides have been updated with the finalised descriptors, and can be found on [MBS Online](#) at: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-CardiacServices1Aug20>.

**Q70. Will the online checker tool be available from 1 August 2020?**

Yes, the items are live and can be checked on Health Professional Online Services (HPOS), noting that claiming is prospective from 1 August 2020.

**Q71. What is the definition of a “financial relationship”?**

“Financial relationship” refers to where the referring practitioner is a member of a group of practitioners, and the providing practitioner is also a member of this group. In this scenario, both the requestor and provider potentially financially benefit from the MBS service provided.

*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.*