Australian Government
Department of Health and Aged Care

Replication of three items into the Relative Value Guide for Anaesthesia

Last updated: 4 January 2024

- On 1 March 2024, three new Medicare Benefits Schedule (MBS) items will be added to the for Relative Value Guide (RVG) for anaesthesia services to align with contemporary clinical practice and support high-value care.
- These items, being replicated from the General Medical Table (GMST), was supported by the Medical Services Advisory Committee Executive (MSAC) in December 2022 and approved by Government for funding on the MBS in the 2023-2024 Budget.
- These new RVG items will allow patients to access MBS benefits for services they receive while under anaesthesia.

What are the changes?

Effective 1 March 2024, there will be three new items added into group T10 subgroup 19 of the RVG. These three new RVG items replicate existing GMST items 13703, 40018 and 55135:

- Item 13703 (for blood transfusion services) will be replicated into item 22052.
- Item 40018 (for the insertion of lumbar cerebrospinal fluid drain) will be replicated into item 22053.
- Item 55135 (for real time transoesophageal echocardiograph) will be replicated into item 22054.

These changes will allow anaesthetists to bill for these services when performed in association with the administration of anaesthesia.

Corresponding co-claim restrictions will also be introduced into items 13703, 40018 and 55135 to prohibit them from being claimed together with items 22052, 22053 and 22054 respectively.

Why are the changes being made?

Section 16 of the *Health Insurance Act 1973* excludes benefits, except with the approval of the Minister, from being paid to anaesthetists performing professional services in association with the administration of anaesthesia. Replicating these items into sub-group 19 of the RVG will allow anaesthetist to co-claim these services.

The listing of this service was recommended by the MSAC in December 2022. Further details about MSAC applications can be found on the MSAC website.

The listing was announced by the Australian Government as part of the 2023-24 Budget.

What does this mean for providers?

Providers have a responsibility to ensure that any services they bill to Medicare fully meet the eligibility requirements outlined in the legislation.

How will these changes affect patients?

Patients will be able to access benefits for services that have been performed by anaesthetists in association with the administration of anaesthesia. These services, when performed by anaesthetists, have previously resulted in higher out-of-pocket costs to patients as the anaesthetist was not able to bill the MBS for these services.

Who was consulted on the changes?

The introduction of these new items was endorsed by MSAC in December 2022 and approved for funding on the MBS in the 2023-24 Budget. MSAC appraises new medical services proposed for public funding and provides advice to the Government on whether a new medical service should be publicly funded (and if so, its circumstances) on an assessment of its comparative safety, clinical effectiveness, cost effectiveness, and total cost, using the best available evidence.

The original submission put to MSAC sought the replication of 10 procedural items into the RVG. This submission was provided to the Neurosurgical Society of Australasia, the Australian Society of Head & Neck Surgeons, the Australasian Society for Ultrasound in Medicine, the Australian Diagnostic Imaging Association, the Royal Australian and New Zealand College of Radiologists, the Australian and New Zealand College of Anaesthetists, the Australian and New Zealand Society of Cardiac Thoracic Surgeons, the Australian Society of Medical Perfusion, the Australian and New Zealand Association of Neurologists and the Australian and New Zealand Society of Vascular Surgeons. Following this feedback and consideration by MSAC, three of the original 10 items were recommended for replication.

More information about this specific MSAC application, including a public summary document can be accessed at www.msac.gov.au.

How will the changes be monitored and reviewed?

The claiming of anaesthesia items will continue to be subject to MBS compliance checks, which may require a provider to submit evidence to substantiate that services were validly claimed.

The new MBS anaesthesia items will be reviewed post implementation.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking ‘Subscribe’.

The Department of Health and Aged Care provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

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

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

The data file for software vendors when available can be accessed via the Downloads page.

New item descriptors (to take effect 1 March 2024)

Category: 3. THERAPEUTIC PROCEDURES

Group: 10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

Subgroup: 19. Therapeutic And Diagnostic Services

22052

Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies

(6 basic units)

Fee: $130.80 Benefit: 75% = $98.10 Benefit: 85% = $111.20

Private Health Insurance Classification:

- **Clinical category:** Support List
- **Procedure type:** Unlisted

22053

Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies

(6 basic units)

Fee: $130.80 Benefit: 75% = $98.10

Private Health Insurance Classification:

- **Clinical category:** Support List
- **Procedure type:** Unlisted

22054

Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service:

a) **is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and**
b) **includes Doppler techniques with colour flow mapping and recordings on digital media; and**
c) **is performed during cardiac valve surgery (replacement or repair); and**
d) **incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and**
e) **is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and**
f) **is provided on the same occasion as the administration of anaesthesia by the same anaesthetist**

(18 basic units)

Fee: $392.40 Benefit: 75% = $294.30

Private Health Insurance Classification:

- **Clinical category:** Support List
- **Procedure type:** Unlisted

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 factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.