Emergency Medicine Changes FAQs

Last updated: 24 February 2020

- This change is effective from 1 March 2020.
- A factsheet summarising what the change is, why the change has been made, how it will affect stakeholders and what they need to do is available on MBS Online.
- More information about the change is provided below, in response to frequently asked questions. If you cannot find the information you need, please contact the Department of Health at askMBS@health.gov.au.
- To subscribe to future MBS Online updates, visit www.mbsonline.gov.au and click 'Subscribe'.

Why are the changes being made?

On 1 March 2020, there will be a revised structure for items for emergency medicine services provided at recognised emergency medicine departments of private hospitals. The revised structure includes replacing existing emergency medicine attendance items with a new base item structure for emergency medicine physicians. A range of emergency medicine procedure items have been introduced to be claimed in conjunction with the new base items. Mirror items are included to encourage doctors to gain emergency medicine experience. The fee for these items is 75% of the equivalent emergency medicine physician service.

The revised structure contains 18 new attendance items in Group A21, 18 new procedure items in new subgroup 14 in Group T1 and deletes 11 items in Group A21.

These changes are a result of a review by the MBS Review Taskforce. The Taskforce found that changes to emergency medicine services were required to reflect the skill, time and risks associated with treating complex patients, encourage best practice, support patient care and safety, simplify the MBS and provide greater billing transparency to ensure MBS services provide value to the patient and the healthcare system.

The MBS Review Taskforce was informed by the Intensive Care and Emergency Medicine (ICEM) Clinical Committee and extensive discussion with key stakeholders. More information about the Taskforce and associated Committees is available in Medicare Benefits Schedule Review in the consumer section of the Department of Health website (www.health.gov.au).

For information about the changes to intensive care items arising from the MBS Review, please refer to the intensive care communications material on the MBS Online website.

How have these changes been communicated to stakeholders?

Prior to the 1 March 2020 listing, the Department circulated communication materials (including factsheets about the changes) to relevant professional groups and encouraged dissemination of these materials to fellows and other members. Information was also made available through the MBS website (www.mbsonline.gov.au).

Frequently asked questions

Claiming emergency medicine services from 1 March 2020

Will the new emergency medicine item structure be implemented retrospectively or prospectively?

The new MBS emergency medicine items will be implemented prospectively from 1 March 2020. Clinicians should continue to provide services according to best practice using the item number that best describes the indication for the service.

Group A21 Emergency Medicine Attendance Items

Will I still be able to bill against the previous emergency medicine attendance items (items 501 – 536)?

No. Previous emergency medicine attendance items 501, 503, 507, 511, 515, 519, 520, 530, 532, 534 and 536 have been deleted and replaced with the new attendance item structure (items 5001 to 5044). Providers will not be able to bill against items 501 to 536 after 1 March 2020.

MBS funded services are processed according to date of service, therefore services delivered prior to 1 March 2020 and billed against items 501 to 536 will remain valid and will be processed, even if they are processed by Medicare after implementation of the new items.

Emergency medicine physicians and other medical practitioners should use the new emergency medicine MBS item structure (attendance items 5001 to 5044) and add-on procedure items (14255 to 14288) from 1 March 2020.

Are there guidelines to define the differences between the three tiered base attendance item complexity levels to assist appropriate billing (items 5001 to 5036)?

Yes. Explanatory Note AN.0.60 provides examples of the clinical indications and professional involvement for each of the the complexity levels (Ordinary Complexity, Complexity that is more than Ordinary but not High, and High Complexity). Explanatory notes explain the service requirements in more detail and outline the differing levels of professional involvement required during emergency attendances, based on the number of differential diagnoses and comorbidities that require consideration.

Am I able to bill procedures such as electrocardiograms (ECGs) and blood sampling separately from the attendance items?

Explanatory Note AN.0.60 provides guidance on routine point-of-care procedures that form part of the standard of care received in an emergency attendance and should be considered an integral component of the attendance items. These procedures include:

- ECGs
- In-dwelling urinary catheterisation
- Venous and arterial blood sampling
- Point-of-care ultrasound in conjunction with procedures such as vascular access or nerve block

Am I able to bill ultrasound services separately from the attendance items?

The use of ultrasound for sting lines and location nerves, FAST scans and in per arrest situations is considered standard of care and is included in complex consult items, resuscitation items and anaesthesia items.

Those medical practitioners with DDU qulaifications who can access the radiology schedule for diagnostic ultrasound can do so but should ensure the billing of these items complies with those item specifications including storage of images, writing of a report and access to the images and report for other medical practitioners.

How do I determine patient eligibility for the Goals of Care items (items 5039, 5041, 5042 and 5044)?

The goals of care items 5039, 5041, 5042 and 5044 are applicable to patients who are 'gravely ill and lacking current goals of care' as defined under the *Health Insurance (General Medical Services Table) Regulations.*

Patients with existing goals of care plans are eligible if such records cannot be readily be retrieved by medical practitioners; or if their condition has changed to the point the record does not reflect the patient's current medical condition and it is reasonable for new goals of care to be developed.

Benefits are paid only once per patient admission. Items 5039, 5041, 5042 and 5044 should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.

Is there an explanatory note for the Goals of Care items?

Yes. Explanatory Note AN.0.61 provides additional guidance on the service requirements for the use of items 5039, 5041, 5042 and 5044. The definitions referred to in the notes for 'gravely ill patient' and 'preparation of goals of care' are provided in the *Health Insurance (General Medical Services Table) Regulations.*

Group T1, Subgroup 14 Emergency Medicine Procedure Add-on Items

Can I still use other MBS therapeutic and procedural items for emergency medicine services?

It is expected that emergency physicians and medical practitioners will utilise the new emergency medicine therapeutic and procedural add-on items when performed in a recognised private emergency department. These items may only be claimed in conjunction with, and in addition to, the emergency medicine attendance items (5001 to 5044). Chemical or physical restraints (items 14277 and 14278) may be performed as a standalone service or in conjunction with an emergency attendance item.

Explanatory Note TN.1.22 provides examples of the services and professional involvement for the add-on procedure items. The add-on items cover the most common procedural and therapeutic services and are intented to provide billing transparency for patients and reduce the previous administrative burden of claiming a signficiantly high range of procedural items across the MBS.

Only in such circumstances where the add-on items do not cover a service performed in emergency medicine, should doctors perform other procedural and therapeutic items on the *Health Insurance (General Medical Services Table) Regulations* for emergency medicine services, where clinically relevant. Doctors should make appropriate references in their clinical notes.

Are there guidelines on what is considered a 'minor procedure' and a 'procedure'?

Yes. Explanatory Note AN.0.60 provides examples of the types of services and professional involvement for 'minor procedures' and 'procedures'. These services include, but are not limited to, sutures, foreign body removal, wound management, burn dressings, bladder aspiration, cardioversion, PEG tube replacement, etc.

Where multiple procedures are performed per patient attendance, the relevant procedure item/s may be billed more than once where clinically relevant for the appropriate treatment of the patient.

What is the billing practice for attendance and procedure items in cases where patients require resuscitation or anaesthesia and a second doctor is required to administer the service?

Patients requiring procedural sedation or resuscitation routinely require a second doctor to assist with access, airway management or other procedures as required. It is the expectation that, in cases where a second doctor is required to provide the resuscitation service, only one emergency medicine attendance item may be billed with either the primary or secondary doctor billing a resuscitation or anaesthesia item.

Items under Subgroup 14 with the 'Anaesthesia' notation allow for Medicare benefits to be paid for a second medical practitioner to provide the anaesthesia service. Where the anaesthesia service is provided by an emergency physician or medical practitioner, anaesthesia items 14280 and 14283 would be claimed. Specialist anaesthetists may not claim items 14280 and 14283 but would provide the service under a relative value guide episode in T7 or T10 of the GMST.

Can I still claim femoral nerve blocks/regional anaesthesia MBS items in addition to the base attendance item without using the new emergency medicine item numbers (items 14280 and 14283)?

The new emergency medicine anaesthesia items (14280 and 14283) provide for anaesthesia (whether general anaesthesia or not).

Femoral nerve blocks and regional anaesthesia provided in a recognised private emergency department should be claimed under item numbers 14280 and 14283, provided all other elements of the item descriptor are met.

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.