Australian Government
Department of Health

Quick reference guide

MBS Review recommendations: Intensive Care services

Date of change: **1 March 2020**

Amended items: 13815 13842 13848 13851 13854

New items: 13832 13834 13835 13837 13838 13840 13899

Deleted items: 13847 14200

Revised structure

- The revised structure contains seven new items, five amended items and deletes two items.
- The revised structure clarifies existing items, supports access to contemporary practice of intensive care services and simplifies the Medicare Benefits Schedule (MBS).
- Note that amendments will also be made to explanatory notes TN.1.9, TN.1.10 and TN.1.11 to align with item changes.
- The *Health Insurance (General Medical Services Table) Regulations 2019* wording for the MBS item descriptors has been used in this document.

Patient impacts

- Patients will receive Medicare rebates for intensive care services that are clinically appropriate and reflect modern clinical practice.

Restrictions or requirements

- Items 13815 (central vein catheterisation)
  - > This item is amended to include the use of ultrasound guidance where clinically appropriate.
  - > This item cannot be co-claimed with ultrasound service items in the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019*.
  - > This item cannot be co-claimed with item 13318 for central vein catheterisation in a person under 12 years of age.
  - > Further information is provided in Explanatory Note TN.1.10.

- Item 13832 (peripheral cannulation for veno-arterial extracorporeal life support)
  - This new item provides for the use of ultrasound guidance where clinically appropriate.
  - This item cannot be co-claimed with ultrasound service items in the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019*.
  - Further information is provided in Explanatory Note TN.1.10.

- Item 13840 (peripheral cannulation for veno-venous extracorporeal life support)
  - This new item provides for the use of ultrasound guidance where clinically appropriate.
  - This item cannot be co-claimed with ultrasound service items in the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019*.
  - Further information is provided in Explanatory Note TN.1.10.

- Item 13842 (Intra-arterial cannulation for intra-arterial pressure monitoring and/or arterial blood sampling)
  - This item is amended to include the use of ultrasound guidance where clinically appropriate.
  - This item cannot be co-claimed with ultrasound service items in the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019*.
  - Further information is provided in Explanatory Note TN.1.10.

- Item 13899 (preparation of goals of care)
  - This new item is applicable to patients who are gravely ill and either have no record of a current goals of care plan; or such records cannot be readily retrieved by the medical practitioners; or it is reasonable to expect that the current goals will change substantially.
  - A patient who is categorised as being gravely ill is one who meets the definition of a ‘gravely ill patient lacking current goals of care’ in the *Health Insurance (General Medical Services Table) Regulations 2019*.
  - This item is applicable to the provision of goals of care services for patients outside an intensive care unit.
  - This item cannot be co-claimed with item 13870 or item 13873 on the same day for the management of a patient in an intensive care unit.
  - Further clarification, including definitions of eligible patients, is provided in Explanatory Note TN.1.11.

Amended item 13815 – Central vein catheterisation

Overview: Central vein catheterisation, amended to include the use of ultrasound guidance.

Descriptor: Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneioius or open exposure, other than a service to which item 13318 applies. (Anaes.) No separate ultrasound item is payable with this item.

MBS fee: $115.45 (previously $86.60). The fee has been increased to allow for the use of ultrasound services.

Benefit: 75% = $86.60 85% = $98.15

Amended item 13842 – Intra-arterial cannulation

Overview: Intra-arterial cannulation, amended to include the use of ultrasound guidance.

Descriptor: Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both).

MBS fee: $95.05 (previously $70.40). The fee has been increased to allow for the use of ultrasound services.

Benefit: 75% = $71.30 85% = $80.80

Amended item 13848 – Counterpulsation by intra-aortic balloon

Overview: Consolidation of items (13847 and 13848) to remove the distinction between management of counterpulsation by intraaortic balloon services performed on the first day and services performed on subsequent days. Item 13847 has been deleted. Item 13848 has been amended to apply to management of counterpulsation by intraaortic balloon on any day, including the first.

Descriptor: Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day – each day.

MBS fee: $158.60 (previously $133.15). The fee has been increased to allow for the application of the service on the first and subsequent days.

Benefit: 75% = $118.95 85% = $134.85

Amended item 13851 – Ventricular assist devices – first day

Overview: Descriptor terminology updated from 'circulatory support device' to 'ventricular assist device', to clearly reference the intended service. Service applies to the first day.

Descriptor: Ventricular assist device, management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device - first day.

MBS fee: $501.55 (no change)

Benefit: 75% = $376.20 85% = $426.35

Amended item 13854 – Ventricular assist devices – subsequent days

Overview: Descriptor terminology updated from 'circulatory support device' to 'ventricular assist device', to clearly reference the intended service. Service applies to subsequent days after the first day.

Descriptor: Ventricular assist device, management of, for a patient admitted to an intensive care unit, including management of complications arising from implantation or management of the device - each day after the first day.

MBS fee: $116.70 (no change)

Benefit: 75% = $87.55 85% = $99.20

New item 13832 – Veno-arterial cardiopulmonary ECMO via peripheral cannulation – ultrasound guidance

Overview: Introduction of an item to provide veno-arterial cardiopulmonary extracorporeal life support services via peripheral cannulation, including the use of ultrasound guidance.

Descriptor: Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support. No separate ultrasound item is payable with this item.

MBS fee: $895.85

Benefit: 75% = $671.90 85% = $811.15

New item 13834 – Veno-arterial cardiopulmonary ECMO - first day

Overview: Introduction of a new item to provide veno-arterial cardiopulmonary extracorporeal life support services on the first day.

Descriptor: Veno–arterial cardiopulmonary extracorporeal life support, management of—the first day.

MBS fee: $501.55

Benefit: 75% = $376.20 85% = $426.35

New item 13835 – Veno-arterial cardiopulmonary ECMO – subsequent days

Overview: Introduction of a new item to provide veno-arterial cardiopulmonary extracorporeal life support services on subsequent days.

Descriptor: Veno–arterial cardiopulmonary extracorporeal life support, management of—each day after the first.

MBS fee: $116.70

Benefit: 75% = $87.55 85% = $99.20

New item 13837 – Veno-venous pulmonary ECMO - first day

Overview: Introduction of a new item to provide veno-venous pulmonary extracorporeal life support services on the first day.

Descriptor: Veno-venous pulmonary extracorporeal life support, management of—the first day.

MBS fee: $501.55

Benefit: 75% = $376.20 85% = $426.35

New item 13838 – Veno-venous pulmonary ECMO – subsequent days

Overview: Introduction of a new item to provide veno-venous pulmonary extracorporeal life support services on subsequent days.

Descriptor: Veno-venous pulmonary extracorporeal life support, management of—each day after the first.

MBS fee: $116.70

Benefit: 75% = $87.55 85% = $99.20

New item 13840 – Veno-venous pulmonary ECMO via peripheral cannulation – ultrasound guidance

Overview: Introduction of a new item to provide veno-venous pulmonary extracorporeal life support services via peripheral cannulation, including the use of ultrasound guidance.

Descriptor: Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support. No separate ultrasound item is payable with this item.

MBS fee: $600.20

Benefit: 75% = $450.15 85% = $515.50

New item 13899 – Goals of Care

Overview: Introduction of a new item for the provision of goals of care for gravely ill patients outside an intensive care unit.

Descriptor: Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient.

Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day.

MBS fee: $272.15

Benefit: 75% = $204.15 85% = $231.35

Deleted item 13847 – Counterpulsation by intra-aortic balloon – the first day

Services under this item are expected to be claimed under item 13848.

Deleted item 14200 – Gastric lavage

This item is obsolete. Gastric lavage is no longer considered best practice.

To view previous item descriptors and deleted items, visit MBS Online at www.mbsonline.gov.au, navigate to 'Downloads' and then select the relevant time period at the bottom of the page. The old items can then be viewed by downloading the MBS files published in the month before implementation of the changes

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.