Australian Government
Department of Health

Changes to Anaesthesia MBS items FAQs

Last updated: 19 December 2019

- This change is effective from 1 November 2019.
- 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.
- 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.
- To subscribe to future MBS Online updates, visit MBS Online and click 'Subscribe'.

Why are the changes being made?

From 1 November 2019 there will be a revised structure of items for anaesthesia services.

The MBS Reviews Taskforce (the Taskforce) found that some anaesthesia items were overly complex, did not reflect current clinical practice and some items needed to be clarified.

The changes to anaesthesia services have been made to encourage best practice, improve patient outcomes and reduce low value care.

These changes are a result of a review by the Taskforce, which was informed by the Anaesthesia Clinical Committee and extensive discussion with key stakeholders. More information about the Taskforce and associated Committees is available at the Department of Health website. A full copy of the Taskforce's final report can be found at: Taskforce report on Anaesthesia MBS items

How have these changes been communicated to stakeholders?

Prior to the 1 November 2019 listing, the Department circulated communication materials (including factsheets about the changes) to relevant professional groups in September 2019 and encouraged dissemination of these materials to other members and fellows. Information was also made available through the MBS website.

Claiming anaesthesia services from 1 November 2019

What items should be claimed for anaesthesia/perfusion time units under two hours?

Anaesthesia/perfusion time units under two hours have been consolidated so that one item represents a 15 minute interval with a set schedule fee. Mapping of these items is provided below.

Deleted Items	New Item	New MBS Online Descriptor
23021, 23022, 23023	23025	16 MINUTES TO 30 MINUTES
23031, 23032, 23033	23035	31 MINUTES TO 45 MINUTES
23041, 23042, 23043	23045	46 MINUTES TO 1:00 HOUR
23051, 23052, 23053	23055	1:01 HOURS TO 1:15 HOURS
23061, 23062, 23063	23065	1:16 HOURS TO 1:30 HOURS
23071, 23072, 23073	23075	1:31 HOURS TO 1:45 HOURS
23081, 23082, 23083	23085	1:46 HOURS TO 2:00 HOURS

What item can be claimed for introduction of a regional or field nerve block which was previously claimed under items 22040, 22045 or 22050?

Services that were previously claimed under items 22040, 22045 and 22050 can be claimed under the new 22041 from 1 November 2019.

- 22041: Introduction of a plexus or nerve block proximal to the lower leg or forearm, perioperatively performed in the induction room, theatre or recovery room, for post-operative pain management.

What item should banding of haemorroids be claimed under as of 1 November 2019?

Item 20902 has been amended and banding of haemorrhoids can no longer be claimed under this item. Anaesthesia for anorectal endoscopic procedures (which includes banding of haemorrhoids) should be claimed under item 20810.

When and why was item 25012 created?

Item 25012 was introduced under the Health Insurance (Section 3C General Medical Services – Childhood Access to Anaesthesia) Determination 2019 which was registered on the Federal Register of Legislation on the 16 December 2019. Item 25012 is taken to have commenced from 1 November 2019.

Item 25012 (along with item 25015) ensures that children under four years old can access an anaesthesia aged modifier. This change better reflects the anaesthesia complexities of the patients of this age cohort.

How will claims be made for item 25012 for services provided between 1 November 2019 and 15 December 2019?

If an eligible patient was aged three years old and under four years old during this time period, a claim under item 25012 will need to be submitted or resubmitted through the usual Medicare claiming channels.

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.