Changes to MBS items for anaesthesia services factsheet

Last updated: 17 January 2020

- From 1 November 2019, Medicare Benefits Schedule (MBS) items for anaesthesia services are changing to reflect contemporary anaesthesia practice. These changes are a result of the MBS Review Taskforce (Taskforce) recommendations and consultation with stakeholders.
- These changes are relevant for all specialists involved in the management and claiming of anaesthesia services performed in association with an eligible service, consumers claiming these services, private health insurers and private hospitals.
- Billing practices from 1 November 2019 will need to be adjusted to reflect these changes.

What are the changes?

From 1 November 2019, there will be amendments to items, new items, consolidation and deletion of items for anaesthesia services. The revised structure includes:

- 7 new items (23025, 23035, 23045, 23055, 23065, 23075, 23085) to replace 21 items (23021, 23022, 23023, 23031, 23032, 23033, 23041, 23042, 23043, 23051, 23052, 23053, 23061, 23062, 23063, 23071, 23072, 23073, 23081, 23082 and 23083) for time items for procedures under two hours
- 4 new items; 22042 - for introduction of a complex eye block, 18297 - to allow a second medical practitioner to provide assistance with an epidural injection of a blood patch, 22041 replaces 3 items (22040, 22045 and 22050) for nerve blocks without catheter insertion, and 25012 - age modifier for three to four year olds (item 25015 can be claimed for children until they are three years old).
- 31 items are being deleted which include:
    - 1 item that is considered obsolete for (21927) barium enema.
    - 3 items with services to be claimed other existing items for (20705, 20805) diagnostic upper and lower laparoscopy procedures and (20953) endometrial ablation or resection).
    - 3 deleted items as the services under these items are considered part of normal clinical practice (22001) autologous blood collection; (22018) measurement of mechanical or gas exchange of respiratory system and (22070) cardioplegia.
    - 3 deleted items which are being consolidated into new item 22041 (22040, 22045 and 22050) for nerve blocks without catheter insertion).
    - 21 items which are being consolidated into new time items for anaesthetics under two hours (23021, 23022, 23023, 23031, 23032, 23033, 23041, 23042, 23043, 23051, 23052, 23053, 23061, 23062, 23063, 23071, 23072, 23073, 23081, 23082 and 23083).

- 4 amended items (18216, 18219, 18226 and 18227) to include combined spinal-epidural in the descriptors and an amendment to the Explanatory Note for items 18216 and 18226 to clarify that the items cannot be claimed if the additional attendance is to optimise the initial treatment.
- 8 items with schedule fee reductions (20142, 20144, 20145, 20410, 21922, 21926 21936 and 21952) for eye surgery including lens, corneal transplant and vitrectomy; scanning including axial tomography, magnetic resonance and digital subtraction angiography; fluoroscopy; cardioversion; heart 2 dimensional real time transoesophageal examination and diagnostic muscle biopsy for malignant hyperpyrexia.
- 2 items have had schedule fee increases and descriptor amendments (20745 and 20750) for upper abdomen endoscopic and hernia repair procedures.
- 3 amended items with minor wording changes include (22002) for administration of homologous blood or bone marrow already collected and (20160 and 20162) for intranasal procedures and surgery.
- 3 amended items (22012, 22014 and 22025) for arterial pressure monitoring and intraarterial cannulation to clarify the items should be claimed for a patient that is categorised as high risk of complications or becomes categorised as high risk of complications during the procedure. Explanatory Notes have been included in these items to provide clarify the definition of high risk.
- 1 amended item (25015) for anaesthesia age modifier to change the eligible age range.
- 5 amended items (20706, 20790, 20840, 20902 and 21952) for upper abdomen, lower abdomen, anorectal and muscle biopsy procedures to clarify the services.
- 1 new explanatory note (22051) for transoesophageal echocardiography to clarify claiming by appropriately credentialed providers.
- 2 amended Explanatory Note for items (22031 and 22036) for initial intrathecal / epidural injection of a therapeutic substance to clarify that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

To learn more about the changes to anaesthesia, please see the quick reference guide and frequently asked questions.

Why are the changes being made?

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 (ACC) and extensive discussion with key stakeholders. More information about the Taskforce and associated Committees is available Department of Health website. A full copy of the Taskforce's final report can be found at Taskforce report on Anaesthesia MBS items

What does this mean for providers?

Providers will need to familiarise themselves with the changes in the anaesthesia schedule, and any associated rules and explanatory notes. 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 receive Medicare rebates for anaesthesia services that are clinically appropriate and reflect modern clinical practice.

Who was consulted on the changes?

The ACC was established in September 2016 by the Taskforce to provide broad clinician and consumer expertise.

The recommendations from the ACC undertook a consultation process. From 2017, the Department undertook discussions on these recommendations and the MBS Reviews process with the key peak bodies for anaesthesia MBS items which included the Australian Society of Anaesthetists (ASA), the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Medical Association (AMA).

Feedback from stakeholders including peak bodies, colleges, individual health professionals and consumers was considered by the ACC prior to making its final recommendations to the Taskforce.

These changes are a result of the Taskforce endorsed recommendations and consultation with stakeholders.

How will the changes be monitored and reviewed?

Anaesthesia items will be subject to MBS compliance processes and activities, including random and targeted audits which may require a provider to submit evidence about the services claimed.

Significant variation from forecasted expenditure may warrant review and amendment of fees, and incorrect use of MBS items can result in penalties including the health professional being asked to repay monies that have been incorrectly received.

The new and amended 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. You can also subscribe to future MBS updates by visiting MBS Online and clicking ‘Subscribe’. A separate factsheet on item 25012 can be found here.

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

Subscribe to ‘News for Health Professionals’ on the Department of Human Services 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 Department of Human Services website or contact the Department of Human Services on the Provider Enquiry Line – 13 21 50.

The data file for software vendors can be accessed via the MBS Online website under the Downloads page.

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