Australian Government
Department of Health, Disability and Ageing

Amendments to electrocardiogram items 11707 and 11714

Last updated: 27 February 2026

- From **1 March 2026** Medicare Benefits Schedule (MBS) items 11707 and 11714 for electrocardiogram (ECG) testing are changing to ensure patients with heart conditions have better access to ECG services, especially in a primary care setting.
- These changes are relevant for medical practitioners, including prescribed medical practitioners (PMPs), general practitioners (GPs), and specialists and cardiologists, who render ECGs.
- The change will expand the availability of ECG services (11714) to PMPs and GPs, subsequently increasing access to cardiac services for patients.

What are the changes?

From **1 March 2026**, the descriptors for items 11707 and 17714 will be amended to specify:

- Item 11707 will be claimed when a medical practitioner has undertaken a trace for the purpose of forwarding to a specialist or consultant physician for a formal report.
- Item 11714 will be claimed by any medical practitioner including general practitioners, specialists and consultant physicians.
- For private insurance purposes, clinical categories and procedure types remain the same.

    Private Health Insurance Classification:

        Clinical category: N/a – Not hospital treatment

        Procedure type: N/a - Not hospital treatment

Why are the changes being made?

These changes are a result of the second MBS Review Advisory Committee post-implementation review of the 1 August 2020 changes made to the MBS items for electrocardiogram services. The review was informed by the Electrocardiogram Working Group (the Working Group). More information about the overarching MBS Review Taskforce (the 'Taskforce') and associated Committees is available in Medicare Benefits Schedule Review in the consumer section of the Department of Health, Disability and Ageing (the department's) website.

A full copy of the Working Group's final report can be found in the Final Report section of the department's website.

What does this mean for providers?

Specialists were claiming MBS item 11704 for trace and report (in a third-party capacity), MBS item 11705 for report only, and MBS item 11714 for trace and interpretation/clinical note. GPs were only permitted to access MBS item 11707 for trace (without a report), which only required a level of interpretation to direct immediate clinical decision making.

The amendments to ECG items specify:

- Item 11707 (trace only) will only be claimed when a provider has undertaken a trace for the purpose of forwarding to a specialist or consultant physician for a formal report.
- Item 11714 (trace and clinical note), will be claimable by any provider to ensure the medical practitioner claiming the service:
    - has used the ECG to inform clinical decision making during an attendance (or immediately following an attendance);
    - details the clinical indication for the service in the clinical note;
    - includes the interpretation in the context of the indication for the service in the clinical note; and
    - does not require a formal report.

The changes will incentivise clinical decision-making and autonomy so that interpretation of ECG traces is not limited by specialty. Rather, that an MBS benefit should be paid appropriately whoever determines that an ECG trace is required, with subsequent interpretation of results to direct immediate clinical care.

How will these changes affect patients?

Patients will have greater access (with a higher benefit) to ECGs performed by GPs, especially in rural and remote areas as defined by the Modified Monash Model. Rural practitioners may not need to refer patients on to other specialists, thereby saving patients' time and additional medical fees.

Who was consulted on the changes?

The Electrocardiogram Working Group was established in 2023 to provide broad clinician and consumer expertise to the second post implementation review of MBS items for ECG services. The MBS Review included a six-week public consultation process on the proposed changes. The consultation closed on 25 July 2024. Peak clinical bodies were invited to provide feedback as part of the public consultation.

How will the changes be monitored and reviewed?

The impact of these changes will be closely monitored. The department will continue to work with stakeholders following implementation of the changes.

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance

checks and providers may be required to submit evidence about the services they bill. More information about the department's compliance program can be found on its website at Medicare compliance.

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 'Subscribe to the MBS' on the MBS Online website.

The department provides an email advice service for providers seeking advice on interpretation of 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, contact the Services Australia Provider Enquiry Line -13 21 50.

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

Amended item descriptors (to take effect 1 March 2026)

Category 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
Group D1 - Miscellaneous Diagnostic Procedures And Investigations
Subgroup 6 - Cardiovascular
11707 Twelve-lead electrocardiography, trace only, by a medical practitioner, if: ~~(a) the trace:~~ ~~(i) is required to inform clinical decision making; and~~ ~~(ii) is reviewed in a clinically appropriate timeframe to identify potentially serious or life-threatening abnormalities; and~~

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~~(iii) does not need to be fully interpreted or reported on; and~~

(a) the trace is provided to a specialist or consultant physician for a formal report; and

(b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies

Applicable not more than twice on the same day

Note: the service is not provided to the patient as part of an episode of:

i. hospital treatment; or

ii. hospital-substitute treatment.

Fee: $21.45 Benefit: 85% = $18.25

(See para DR.1.4 of explanatory notes to this Category)

Private Health Insurance Classification:

- Clinical category: N/a – Not hospital treatment
- Procedure type: N/a - Not hospital treatment

11714

~~Twelve-lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies~~

Twelve-lead electrocardiography, trace and clinical note, by a medical practitioner if:

(a) the trace is required to inform clinical decision making during or following an attendance; and

(b) the clinical note details the clinical indication for the service; and

(c) the clinical note includes the interpretation in the context of the indication for the service; and

(d) the service does not require a formal report: and

(e) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies

Applicable not more than twice on the same day

Note: the service is not provided to the patient as part of an episode of:

i. hospital treatment; or

ii. hospital-substitute treatment.

Fee: $28.25 Benefit: 85% = $24.05

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(See para DR.1.4 of explanatory notes to this Category)

Private Health Insurance Classification:

- Clinical category: N/a – Not hospital treatment
- Procedure type: N/a – Not hospital treatment

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.