Australian Government
Department of Health, Disability and Ageing

MBS Review recommendations:

85% Project Tranche 2

Date of change: 1 March 2026

List of Amended items that will have 85% and 75% benefit removed

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Key Points

- Under the Medicare Benefits Schedule (MBS), the government subsidises an eligible medical service based on whether the service is provided as part of an episode of hospital treatment or not (out-of-hospital).
- A number of MBS items for specialist procedural services that should only be provided as hospital treatment and billed at 75% of the schedule fee are still able to be claimed at the 85% benefit.
- Billing data shows that these hospital services are being incorrectly billed at the 85% benefit.
- For many of the targeted items, the application of an 85% benefit is an artefact of when 75% benefits for hospital treatment services were introduced to the schedule. The 85% benefit was simply not removed.
- In two consultation phases with clinical peak bodies and specialist colleges, items for removal of 85% benefit were identified. The Department of Health, Disability and Ageing (the department) also wrote to each state or territory health department to advise of the consultation being undertaken.
- In phase one, 55 clinical bodies and specialist colleges were consulted. Of the 965 items reviewed, the 85% benefit was removed from 833 items. The changes were implemented on 1 March 2025.
- In phase 2, the department consulted with 60 clinical peak bodies and specialist colleges. Outcomes of the consultation resulted in a list of 129 MBS items that will have the 85% benefit removed. This means the Extended Medicare Safety Net no longer applies to these items. In addition, 43 MBS items will have the 75% benefit removed as the items can only be claimed in an out-of-hospital environment.
- The changes will ensure the MBS items reflect the settings in which they should be provided and will reduce incorrect billing of out-of-hospital services.

Definition of Hospital Treatment

Currently the definition of hospital treatment is governed by legislation, the *Health Insurance Act 1973* using the definition contained in Division 121-5 (1) (c) of the *Private Health*

Insurance Act 2007. Hospital treatment is treatment provided at a hospital, or treatment that is provided, or arranged, with the direct involvement of a hospital.

Hospital treatment includes services provided to admitted patients, patients in the outpatient department (non-admitted patients) of a declared hospital or in a 'day-hospital' of a declared hospital.

Provider impacts

- Professional services rendered as a hospital treatment attract a 75% benefit.
- The 75% benefit can only be claimed for services provided in the following circumstances, if:
    - the Service is intended to manage a disease, injury or condition; and
    - the Service is provided to a person:
        - by a person who is authorised by a hospital to provide the treatment; or
        - under the management or control of such a person; and
    - either:
        - the Service is provided at a hospital; or
        - the Service is provided, or arranged, with the direct involvement of a hospital
- For the purposes of private health insurance, facilities needing to access 75% benefits can only make claims if they are a declared public or private hospital under conditions stipulated on the department's website at: Hospital declarations | Australian Government Department of Health, Disability and Ageing
- Providers with multiple provider numbers can only use numbers associated with a declared hospital to claim the 75% benefit.
- A service that is provided as hospital treatment at a hospital can be claimed at the 75% benefit only.
- The 85% benefit applies to all non-hospital treatment services except for attendances by general practitioners including services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.

Patient impacts

- For privately funded services, the law (the Health Insurance Act 1973 and the Private Health Insurance Act 2007) is designed so that the Government pays 75% of the Medicare Benefits Schedule (MBS) fee for any hospital treatment.
- If the patient has private health insurance that covers the service, their insurer must pay at least the remaining 25% of the MBS fee. If the patient does not have private health insurance, or their insurance does not cover that service, the patient may need to pay the difference themselves if the provider charges more than the 75% Medicare amount.
- As a result of the reduction in the benefit for the items in scope from 85% to 75%, there will be a minimum of 10% increase in out-of-pocket costs, if not bulk billed.

- The targeted items that have 85% benefit removed have “(H)” applied to their item descriptors.
- A service with the “(H)” in the descriptor means the service can only be provided and claimed for hospital treatment at a declared hospital or where clinically appropriate, on behalf of or arranged by the declared hospital. This includes services provided to admitted patients, patients in the outpatient department (non-admitted patients) of a declared hospital or in a ‘day-hospital’ of a declared hospital.

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.

Amended item descriptors (to take effect 01 March 2026)

Category 3 – Therapeutic Procedures
Group T8 – Surgical Operations
Subgroup 1 - General
30281 Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, ~~under general anaesthesia,~~ other than a service associated with a service to which item 45009 applies ~~(H)~~ (Anaes.) Fee: $139.35 Benefit: 75% = $104.55 and 85% = $118.45 • Private Health Insurance Classification: • Clinical category: Ear, nose and throat • Procedure type: Type B Non-band specific

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.

List of Amended items – items losing the 85% benefit on 1 March 2026

Category 1 – Professional attendances

Group A8 - Consultant Psychiatrist Attendances To Which No Other Item Applies

297 - Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner - an attendance at hospital if the patient:

(a) is a new patient for this consultant physician; or

(b) has not received a professional attendance from this consultant physician in the preceding 24 months;

other than attendance on a patient in relation to whom this item, or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92483 has applied in the preceding 24 months (H)

320 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at hospital (H)

322 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital (H)

324 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital (H)

326 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital (H)

328 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at hospital (H)

Group A15 - GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans

Sub-group 2 - Case Conferences

830 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (H)

832 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines(H)

834 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (H)

835 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

837 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

838 - Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

861 - Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

864 - Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

866 - Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H)

Group A24 - Pain and Palliative Medicine

Subgroup 2 - Pain Medicine Case Conferences

2978 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)

Subgroup 4 - Palliative Medicine Case Conferences

3069 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)

3074 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)

3078 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)

3083 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)

3088 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)

3093 - Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)

Category 2 - Diagnostic Procedures and Investigations

Group D1 - Miscellaneous Diagnostic Procedures and Investigations

Subgroup 3 - Otolaryngology

11600 - Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient, other than a service:

(a) associated with the management of general anaesthesia; and

(b) to which item 13876 applies

(H)

Category 3 - Therapeutic Procedures

Group T1 - Miscellaneous Therapeutic Procedures

Subgroup 1 - Hyperbaric Oxygen Therapy

13015 - Hyperbaric oxygen therapy, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance (H)

13020 - Hyperbaric oxygen therapy, for treatment of decompression illness, gas gangrene, air or gas embolism, diabetic wounds (including diabetic gangrene and diabetic foot ulcers) or necrotising soft tissue infections (including necrotising fasciitis or Fournier's gangrene), or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance (H)

13025 - Hyperbaric oxygen therapy, for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber

greater than 3 hours, including any associated attendance—per hour (or part of an hour) (H)

Subgroup 8 – Haematology

13760 - In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high-dose chemotherapy for management of:

(a) aggressive malignancy; or

(b) malignancy that has proven refractory to prior treatment

(H)

Group T4 – Obstetrics

16567 - Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (H) (Anaes.)

16570 - Acute inversion of the uterus, vaginal correction of, as an independent procedure (H) (Anaes.)

16609 - Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (H) (Anaes.)

16615 - Fetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling—performed in conjunction with a service described in item 16609 (H) (Anaes.)

16618 - Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500 ml being aspirated (H)

Group T8 – Surgical Operations

Subgroup 1 - General

30105 - Pre-auricular sinus, excision of, on a patient under 10 years of age (H) (Anaes.)

Subgroup 3 - Vascular

33070 - Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)

Subgroup 4 - Gynaecological

35527 - Urethral caruncle, symptomatic excision of, if:
(a) conservative management has failed; or
(b) there is a suspicion of malignancy
(H) (Anaes.)

35609 - Cervix, cone biopsy or amputation (H) (Anaes.)

35610 - Cervix, cone biopsy for histologically proven malignancy
(H) (Anaes.)

35674 - Ultrasound guided needling and injection of ectopic pregnancy
(H)

Subgroup 5 - Urological

37204 - Cystoscopy with insertion of prostatic implants for the treatment of benign prostatic hyperplasia (H) (Anaes.)

37205 - Prostate, ablation by water vapour with or without cystoscopy and with or without urethroscopy (H) (Anaes.)

37318 - Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (H) (Anaes.)

37613 – Epididymectomy (H) (Anaes.)

Subgroup 9 - Ophthalmology

42505 - Complete removal of a micro-bypass glaucoma surgery device or devices from the suprachoroidal space or the trabecular meshwork, with or without replacement, following device-related medical complications necessitating complete removal (H) (Anaes.)

42610 - Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage—under general anaesthesia (H) (Anaes.)

42611 - Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage—under general anaesthesia (H) (Anaes.)

42805 - Tantalum markers, surgical insertion to the sclera to localise the tumour base and to assist in planning radiotherapy of choroidal melanomas—one or more of (H) (Anaes.) (Assist)

45629 - Symblepharon, grafting for (H) (Anaes.) (Assist.)

45650 - Rhinoplasty, revision of, if:

(a) the indication for surgery is:

(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or

(ii) significant acquired, congenital or developmental deformity; and

(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes

(H) (Anaes.)

Subgroup 13 – Plastic and reconstruction surgery

45831 - Papillary hyperplasia of the palate, surgical reduction of—cannot be claimed more than once per occasion of service

(H) (Anaes.) (Assist.)

45939 - Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief (H) (Anaes.) (Assist.)

46126 - Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 1% or more but less than 3% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.)

46130 - Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves less than 1% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)

Subgroup 14 – Hand Surgery

46308 - Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed):

(a) realignment procedures;
(b) tendon transfer

—one joint (H) (Anaes.) (Assist.)

46336 - Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed):

(a) capsulectomy;
(b) debridement;
(c) ligament or tendon realignment (or both);

other than a service combined with a service to which item 46495 applies—one joint (H) (Anaes.) (Assist.)

46423 - Delayed repair of extensor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)

46438 - Closed pin fixation of mallet finger (H) (Anaes.)

46441 - Open reduction of mallet finger, including any of the following (if performed):

(a) joint release;
(b) pin fixation;
(c) tenolysis

(H) (Anaes.) (Assist.)

Subgroup 15 – Orthopaedic

47045 - Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by open reduction, including any of the following (if performed):

(a) arthrotomy;
(b) capsule repair;
(c) ligament repair;
(d) volar plate repair

(H) (Anaes.) (Assist.)

47672 - Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed):

(a) arthrotomy;
(b) capsule repair;
(c) removal of loose fragments;
(d) removal of intervening soft tissue;
(e) washout of joint

—one toe (other than great toe) of one foot (H) (Anaes.)

47970 - Open tenotomy of one or more tendons of scapula, with or without tenoplasty, to restore scapula function, other than a service to which another item in this Group applies—applicable once per joint per occasion on which this service is performed (H) (Anaes.)

47973 - Open tenotomy of one or more tendons of elbow, with or without tenoplasty, to restore elbow function, other than a service to which another item in this Group applies—applicable once per joint per occasion on which this service is performed (H) (Anaes.)

49800 - Primary repair of flexor or extensor tendon of foot, including either or both of the following (if performed):

(a) synovial biopsy;
(b) synovectomy;

—one toe (H) (Anaes.) (Assist.)

Group T10 - Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service.

Subgroup 1 - Head

20124 - Initiation of the management of anaesthesia for otoscopy (H)

20146 - Initiation of the management of anaesthesia for biopsy of conjunctiva (H)

20160 - Initiation of the management of anaesthesia for intranasal procedures on nose or accessory sinuses, other than a service to which another item in this Subgroup applies (H)

20164 - Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses (H)

Subgroup 2 - Neck

20305 - Initiation of the management of anaesthesia for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis, causing life threatening airway obstruction (H)

Subgroup 3 - Thorax

20440 - Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum (H)

20475 - Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax (H)

Subgroup 5 – Spinal and spinal cord

20630 - Initiation of the management of anaesthesia for procedures in lumbar region, other than a service to which another item in this Subgroup applies (H)

Subgroup 6 – Upper abdomen

20703 - Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, other than a service to which another item in this Subgroup applies (H)

20750 - Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies (H)

20799 - Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen (H)

Subgroup 7 – Lower abdomen

20803 - Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, other than a service to which another item in this Subgroup applies (H)

20804 - Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (H)

20815 - Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract (H)

20832 - Initiation of the management of anaesthesia for repair of incisional herniae or wound dehiscence, or both, of the lower abdomen (H)

20842 - Initiation of the management of anaesthesia for amniocentesis (H)

20886 - Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen (H)

Subgroup 8 – Perineum

20946 - Initiation of the management of anaesthesia for vaginal birth (H)

20948 - Initiation of the management of anaesthesia for purse string ligation of cervix, or removal of purse string ligature, or removal of purse string ligature (H)

20950 - Initiation of the management of anaesthesia for culdoscopy (H)

20952 - Initiation of the management of anaesthesia for hysteroscopy (H)

20958 - Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (H)

Subgroup 9 – Pelvis (except hip)

21110 - Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (H)

21112 - Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest (H)

21114 - Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest (H)

Subgroup 11 – Knee and popliteal area

21300 - Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the knee or popliteal area, or both (H)

21321 - Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee or popliteal area, or both (H)

Subgroup 13 – Shoulder and axilla

21610 - Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla, including axillary dissection (H)

Subgroup 14 – Upper arm and elbow

21710 - Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, other than a service to which another item in this Subgroup applies (H)

21740 - Initiation of the management of anaesthesia for open procedures on the upper arm or elbow, other than a service to which another item in this Subgroup applies (H)

21770 - Initiation of the management of anaesthesia for procedures on arteries of upper arm, other than a service to which another item in this Subgroup applies (H)

21780 - Initiation of the management of anaesthesia for procedures on veins of upper arm, other than a service to which another item in this Subgroup applies (H)

Subgroup 15 – Forearm wrist and hand

21810 - Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (H)

21850 - Initiation of the management of anaesthesia for procedures on the veins of forearm, wrist or hand, other than a service to which another item in this Subgroup applies (H)

Subgroup 16 - Anaesthesia for burns

21878 - Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves not more than 3% of total body surface (H)

Subgroup 17 - Anaesthesia for radiological or other diagnostic or therapeutic procedures

21900 - Initiation of the management of anaesthesia for injection procedure for hysterosalpingography (H)

21906 - Initiation of the management of anaesthesia for injection procedure for myelography—lumbar or thoracic (H)

21908 - Initiation of the management of anaesthesia for injection procedure for myelography—cervical (H)

21912 - Initiation of the management of anaesthesia for injection procedure for discography—lumbar or thoracic (H)

21914 - Initiation of the management of anaesthesia for injection procedure for discography—cervical (H)

21926 - Initiation of the management of anaesthesia for fluoroscopy (H)

21935 - Initiation of the management of anaesthesia for phlebography (H)

21939 - Initiation of the management of anaesthesia for peripheral venous cannulation (H)

21945 - Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection (H)

21949 - Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation (H)

21955 - Initiation of the management of anaesthesia for electroencephalography (H)

21959 - Initiation of the management of anaesthesia for brain stem evoked response audiometry (H)

21962 - Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method (H)

21965 - Initiation of the management of anaesthesia as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (H)

21970 - Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is confined in the chamber (including the administration of oxygen) (H)

21973 - Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources (H)

21976 - Initiation of the management of anaesthesia for therapeutic nuclear medicine (H)

21980 - Initiation of the management of anaesthesia for radiotherapy (H)

Subgroup 18 - Miscellaneous.

21992 - Initiation of the management of anaesthesia performed on a patient under the age of 10 years in connection with a procedure covered by an item that does not include the word “(Anaes.)” (H)

Subgroup 19 - Therapeutic and diagnostic services performed in connection with the management of anaesthesia.

22052 - Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as

the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies (H)

22053 - Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies (H)

22054 - Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service:

(a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and

(b) includes Doppler techniques with colour flow mapping and recordings on digital media; and

(c) is performed during cardiac valve surgery (replacement or repair); and

(d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and

(e) is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and

(f) is provided on the same occasion as the administration of anaesthesia by the same anaesthetist

(H)

Category 4 - Oral and maxillofacial services

Group O3 – General surgery

51904 - Lipectomy—wedge excision of skin or fat—one excision (H) (Anaes.) (Assist.)

51906 - Lipectomy—wedge excision of skin or fat—2 or more excisions (H) (Anaes.) (Assist.)

52060 - Muscle in the oral and maxillofacial region, excision of (H) (Anaes.)

52073 - Salivary gland, repair of cutaneous fistula of (H) (Anaes.)

Group O5 - Preprosthetic

52621 - Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (H) (Anaes.) (Assist.)

Group O6 – Neurosurgical

52824 - Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (H) (Anaes.) (Assist.)

52826 - Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (H) (Anaes.)

Category 7 - Cleft and Craniofacial Services

Group C1 - Cleft and Craniofacial Services

75610 - Surgical procedure for intraoral implantation of an osseointegrated fixture and placement of transmucosal abutments where the patient is referred by a referring dentist or medical practitioner (H)

List of Amended items – items losing the 75% benefit on 1 March 2026

Category 1 - Professional Attendances

Group A8 - Consultant Psychiatrist Attendances To Which No Other Item Applies

296 - Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner - an attendance at consulting rooms if the patient:

(a) is a new patient for this consultant physician; or

(b) has not received a professional attendance from this consultant physician in the preceding 24 months;

other than attendance on a patient in relation to whom this item, or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92483 has applied in the preceding 24 months

300 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient

302 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient

304 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient

306 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient

308 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient

310 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient

312 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient

314 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient

316 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient

318 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient

319 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes at consulting rooms, if:

(a) the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment; and

(b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient

330 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital

332 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital

334 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital

336 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital

338 - Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an

attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital

Group A40 - Telehealth and phone attendance services

91827 - Video attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and
(b) the attendance was not more than 15 minutes in duration;

if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91828 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91828 - Video attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was at least 15 minutes, but not more than 30 minutes in duration;

if that attendance and another attendance to which item 296, 297, 299, or any of items 300, 302, 304, 306 to 308, 91827, 91829 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91829 - Video attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was at least 30 minutes, but not more than 45 minutes in duration;

if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827, 91828, 91830, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91830 - Video attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was at least 45 minutes, but not more than 75 minutes in duration;

if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91829, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91831 - Video attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was at least 75 minutes in duration;

if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91830, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91837 - Phone attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was not more than 15 minutes duration;

Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91838, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91838 - Phone attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner and

(b) the attendance was at least 15 minutes, but not more than 30 minutes in duration;

Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year

91839 - Phone attendance for a person by a consultant psychiatrist; if:

(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and

(b) the attendance was at least 30 minutes, but not more than 45 minutes in duration

Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91838 and 92437 applies have not exceeded 50 attendances in a calendar year

91868 - Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91869, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

91869 - Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

91870 - Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

91871 - Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 45 minutes but not more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

91872 - Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91873, or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

91873 - Video attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the psychiatrist by a referring practitioner, where the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment, if that attendance and another attendance to which any of items 296, 297, 299 or any of items 300, 302, 304, 306, 308, 319, 92437, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91872 or 91879 to 91881 applies has not exceeded 160 attendances in a calendar year for the patient

91879 - Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91880, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient

91880 - Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient

91881 - Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831,

91837 to 91839, 91868 to 91873, 91879, 91880 or 92437 applies exceed 50 attendances in a calendar year for the patient

92437 - Video attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner:

(a) if the patient:

i. is a new patient for this consultant physician; or
ii. has not received an attendance from this consultant physician in the preceding 24 months; and

(b) the patient has not received an attendance under this item, or item 91827 to 91831, 91837 to 91839, 92455 to 92457, 91868 to 91873, 91879 to 91881 or item 296, 297, 299, 300, 302, 304, 306 to 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344 or 346 of the general medical services table, in the preceding 24 months

Category 5 - Diagnostic Imaging Services

Group I3 - Diagnostic Radiology

57541 - Fee for a service rendered using first eligible x-ray procedure carried out during attendance at residential aged care facility, where the service has been requested by a practitioner who has attended the patient in person and the request identifies one or more of the following indications:

(a) the patient has experienced a fall and one or more of the following items apply to the service 57509, 57515, 57521, 57527, 57703, 57709, 57712, 57715, 58521, 58524, 58527; or
(b) pneumonia or heart failure is suspected and item 58503 applies to the service; or
(c) acute abdomen or bowel obstruction is suspected and item 58903 applies to the service.

This call-out fee can be claimed once only per visit at a residential aged care facility irrespective of the number of patients attended.

NOTE: If the service is bulked billed 95% of the fee is payable. The multiple services rule does not apply to this item.

(R)

Category 6 - Pathology Services

Group P9 - Simple Basic Pathology Tests

73839 - Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk - not more than once in a 12 month period.

(Item is subject to restrictions in rule PR.9.1 of explanatory notes to this category)

73840 – Quantitation of glycosylated haemoglobin performed in the management of established diabetes – each test to a maximum of 4 tests in a 12 month period.

(Item is subject to restrictions in rule PR.9.1 of explanatory notes to this category)

73844 - Quantitation of urinary albumin/creatine ratio in urine on a random spot collection in the management of patients with established diabetes or patients at risk of microalbuminuria

Category 8 - Miscellaneous Services

Group M15 - Diagnostic Audiology Services

82301 - Audiology health service, consisting of programming an auditory implant or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if:

(a) the service is performed on the patient individually and in person; and

(b) a service to which item 11302, 11342 or 11345 applies has not been performed on the patient on the same day

Applicable up to a total of 4 services to which this item, item 82302 or item 82304 applies on the same day

Group M18 - Allied Health Telehealth and Phone Services

93048 - Video attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner if:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

(i) a chronic condition; and

(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and

(iii) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and

(c) the person is referred to the eligible allied health practitioner by a medical practitioner using a referral form issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the service is provided to the person individually; and

(e) the service is of at least 20 minutes duration; and

(f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b):

(i) if the service is the only service under the referral—in relation to that service; or

(ii) if the service is the first or the last service under the referral—in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters;

to a maximum of 10 services (including any services to which this item or 93000, 93013 or 93061 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health Determination applies) in a calendar year

Group M19 - Midwifery telehealth and phone services

Subgroup 1 - Midwifery video services

91215 - Routine postnatal video attendance by a participating midwife, lasting at least 40 minutes

Subgroup 2 - Midwifery Phone Services

91219 - Routine antenatal phone attendance by a participating midwife, lasting at least 40 minutes

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.