MBS Review Advisory Committee

Vascular Interventional Radiology Review

FINAL REPORT

February 2026

Contents

Summary

In April 2022, the then Department of Health and Aged Care nominated and requested a review by the Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) of vascular interventional radiology (VIR) services. This work would review and expand on the MBS Review Taskforce's *Report on vascular services items*, published in 2020. The VIR Working Group (VIRWG) was established to advise the MRAC and comprises 4 MRAC members, including in the roles of Chair and consumer representative, as well as clinical experts nominated by several peak bodies.

The department sought the MRAC's advice on the following issues:

1. The creation of a new standalone section of MBS 'Category 3, Group T8 – Surgical Operations' for vascular-related interventional radiology (IR) procedures, or the renaming of the 'Vascular' subgroup to 'Vascular, Endovascular and Interventional Radiology'.
2. The creation of new MBS items for IR / interventional neuroradiology (INR) procedural and diagnostic services as proposed by the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Australian and New Zealand Society of Neuroradiology (ANZSNR), noting that, while RANZCR supported the range of INR procedures proposed by ANZSNR, it also provided a list of new MBS items distinct from ANZSNR's set of proposed new and amended items.

   Additionally, whether the existing diagnostic angiography fees for specific anatomical sites (corresponding with the procedural site) should be included or considered an acceptable guide with respect to the proposed IR/INR bundled procedural items?
3. The support for the Taskforce recommendation to align the proposed INR items with the neurosurgery items, noting that INR procedures are also undertaken by neurosurgeons and neurologists.
4. The amendment (where possible) of existing vascular open surgical approach items to include endovascular or hybrid repair (for example, by any approach), or the creation of new items.

PICO process

VIRWG members reviewed existing and new MBS items for a wide range of IR/INR and surgical services using the PICO (population, intervention, comparator, outcomes) process. The VIRWG considered the PICOs in line with the MBS Continuous Review Guiding Principles.

The VIRWG recognised that it was not feasible for it to complete the development of the proposed new and amended MBS items, and that this should be undertaken by the department in consultation with all relevant stakeholders. It therefore agreed that the draft MBS items would not be included in the MRAC report.

Recommendations

The VIRWG made 13 final recommendations (see List of recommendations). Four draft recommendations were not finalised by the VIRWG because members could not reach consensus on them. These draft recommendations were also not universally supported during the public consultation.

Considerations for implementation

The VIRWG noted several issues that may affect implementation of their recommendations.

First, the VIRWG acknowledged the rapidly evolving clinical landscape in which vascular surgery and IR/INR operate, due in part to technological advancements. There has been a perceptible clinical shift towards more endovascular services and less open surgery, particularly for arterial diseases. In the future, the integration of genetic factors, use of artificial intelligence (AI) and robot-assisted procedures are expected to play a vital role in improving technical success across many settings, potentially having a profound influence on how vascular medicine is conducted.

Second, the VIRWG understood that its recommendations would likely affect Medicare expenditure and that the department must consider the budget impact of any proposed MBS changes. Members supported reinvesting any Medicare cost savings achieved from their recommendations into the vascular/IR/INR sector, to promote service sustainability and improve patient access.

Finally, significant improvements in service effectiveness may be achieved by reforming the current set of diagnostic angiography items and bundling diagnostic angiography and fluoroscopy with a range of procedural services.

List of recommendations

Recommendation 1

Simplify and modernise diagnostic-only angiography services by reducing the current set of items for diagnostic angiography to 2 items. Ensure that procedures sitting outside of the vascular/interventional radiology/interventional neuroradiology section of the MBS do not lose access to angiography and fluoroscopy services that are clinically necessary.

Recommendation 2

When possible, include angiography and fluoroscopy in vascular procedures.

Recommendation 3

Remove the inclusion of aftercare in MBS items for vascular, interventional radiology and interventional neuroradiology procedures.

Recommendation 4

Invasive diagnostic services should only be provided as preparation for some form of intervention, when clinically appropriate.

Recommendation 5

The approach for existing MBS items for vascular procedures should be agnostic (that is, open, endovascular or hybrid) where and when it is clinically appropriate.

Recommendation 6

Ensure that the MBS fees are consistent for open surgical, hybrid and endovascular treatment approaches, when this is appropriate and reasonable. A complexity modifier will be used to adjust the MBS fee for a service based on the complexity of the procedure, where appropriate.

Recommendation 7

When an endovascular equivalent to an open surgical procedure does not exist, there will be no change to the MBS item descriptor.

Recommendation 8

Develop complexity modifiers for procedures with additional clinical components compared to what is expected of a standard procedure.

Recommendation 9

MRAC endorses the following and requests that the Department consider: retaining the title of MBS ‘Group T8, Subgroup 3 – Vascular’ and creating a new subheading for interventional radiology items; and including neurointerventional items in MBS ‘Group T8, Subgroup 7’ and amending its title from ‘Neurosurgical’ to ‘Neurosurgical and Neurointerventional’.

Recommendation 10

Ensure that MBS item descriptors and explanatory notes describe clinical procedures using wording that is consistent with the terminology used in clinical practice.

Recommendation 11

That the Department review current private health insurance membership rules with a view to extending eligibility for vascular, endovascular, interventional radiology and interventional neuroradiology services to Bronze tier policies.

Recommendation 12

That the Department review the inclusion or removal of new devices on the Prescribed List of Medical Devices and Human Tissue Products, considering both the funding of non-implantable devices required during vascular procedures and the funding of related consumables not otherwise covered by private health insurance.

Recommendation 13

MRAC notes the potential benefits of pre-surgery exercises / pre-operative optimisation strategies and refers this matter to MRAC's Chronic Conditions Management Review for consideration.

Acronyms

ANZAN	Australian and New Zealand Association of Neurologists
ANZSNR	Australian and New Zealand Society of Neuroradiology
ANZSVS	Australian and New Zealand Society of Vascular Surgery
DSA	digital subtraction angiography
INR	interventional neuroradiology
IR	interventional radiology
IRSA	Interventional Radiology Society of Australasia
MBS	Medicare Benefits Schedule
MRAC	MBS Review Advisory Committee
NSA	Neurosurgical Society of Australasia
PICO	population, intervention, comparator, outcomes
PL	Prescribed List of Medical Devices and Human Tissue Products
RANZCR	Royal Australian and New Zealand College of Radiologists
VIR	vascular interventional radiology
VIRWG	Vascular Interventional Radiology Working Group

Background

In 2018, the Medicare Benefits Schedule (MBS) Review Taskforce established the Vascular Clinical Committee to review 290 MBS items related to vascular services, encompassing:

- vascular T8 surgical items
- vascular-related digital subtraction angiography (DSA) items
- diagnostic imaging items related to vascular care.

The review, completed in 2020, identified a significant gap related to vascular interventional radiology (VIR) services on the MBS.

Due to time constraints, the Clinical Committee was unable to review and provide recommendations on new or amended VIR procedures, particularly those that are not routinely performed by vascular surgeons. Currently, many interventional radiology (IR) procedures are billed under existing MBS items that have broad descriptors and rebates that do not reflect the procedures accurately in terms of time or complexity.

After the Taskforce's *Report on vascular services items* was published, further input was provided by the Royal Australian and New Zealand College of Radiologists (RANZCR), the Interventional Radiology Society of Australasia, the Australian and New Zealand Society of Neuroradiology (ANZSNR) and the Australian and New Zealand Society of Vascular Surgery (ANZSVS). The additional input focused on 2 of the Taskforce's recommendations:

- A single, low-fee diagnostic angiography-only item would not allow for variations in time and complexity and would therefore be unworkable in practice.
- Noting the significant gap identified by the Taskforce regarding vascular-related IR procedures, RANZCR and ANZSNR proposed new and amended procedural and diagnostic IR and interventional neuroradiology (INR) items for procedures not currently listed on the MBS.

Key recommendations from the MBS Review Taskforce

The relevant recommendations from the Taskforce's report were as follows:

1. Develop a distinct place for endovascular/IR items on the MBS. Options for change are
    - change the name of the vascular T8 section to 'Vascular, Endovascular and Interventional Radiology'
    - create a new standalone INR section of the MBS to reflect the growing number of interventional services provided, many of which are mainly performed by interventional radiologists
    - align INR items with the neurosurgery section of the MBS.
2. Where there is an endovascular approach equivalent to an existing open vascular surgical T8 item, amend the open approach item descriptor to allow the endovascular approach (when appropriate).

    (Noting that when there is a substantial difference in time and/or complexity of an endovascular procedure compared with the equivalent open procedure, setting the same fee for both approaches may not be reflective of the competing inputs.)

3. Implement a single MBS diagnostic DSA item.

Vascular Interventional Radiology Working Group

In April 2022, the then Department of Health and Aged Care requested that the MRAC review VIR services. This work would review and expand on the Taskforce's report.

The department sought the MRAC's advice on the following issues:

1. The creation of a new standalone section of MBS 'Category 3, Group T8 – Surgical Operations' for vascular-related IR procedures, or the renaming of the 'Vascular' subgroup to 'Vascular, Endovascular and Interventional Radiology'.
2. The creation of new MBS items for IR/INR procedural and diagnostic services as proposed by RANZCR and ANZSNR, noting that, while RANZCR supported the range of INR procedures proposed by ANZSNR, it also provided a list of new MBS items distinct from ANZSNR's set of proposed new and amended items.

   Additionally, whether the existing diagnostic angiography fees for specific anatomical sites (corresponding with the procedural site) should be included or considered an acceptable guide with respect to the proposed IR/INR bundled procedural items?
3. The support for the Taskforce recommendation to align the proposed INR items with the neurosurgery items, noting that INR procedures are also undertaken by neurosurgeons and neurologists.
4. The amendment (where possible) of existing vascular open surgical approach items to include endovascular or hybrid repair (for example, by any approach), or the creation of new items.

The VIR Working Group (VIRWG) was established to advise the MRAC on this topic. It comprised 4 MRAC members, including in the roles of Chair and consumer representative, as well as clinical experts nominated by the following peak bodies:

- ANZSNR
- Australian and New Zealand Association of Neurologists
- Australian and New Zealand Society of Vascular Surgery
- Interventional Radiology Society of Australasia
- Neurosurgical Society of Australasia
- RANZCR.

The VIRWG met via teleconference on 8 occasions: 21 March 2023, 2 May 2023, 8 November 2023, 20 February 2024, 26 March 2024, 23 May 2024, 8 August 2024 and 18 November 2025. In addition, a significant amount of work was progressed out-of-session.

PICO assessments

VIRWG members reviewed existing MBS items and proposed new ones for a range of VIR/INR and surgical services using the PICO (population, intervention, comparator, outcomes) approach. Members contributed 75 PICOs, and an additional PICO was received in early 2025 as a referral from the Medicare Services Advisory Committee (MSAC) Secretariat. Of the 76 PICOs, 17 were incorporated into or replaced by other PICOs. One was identified as better suited for MSAC's consideration.

The VIRWG considered the PICOs in line with the MBS Continuous Review Guiding Principles (Appendix 1) and the assessment tool, which is based on the PICO framework (Appendix 2). The proposed MBS item descriptors were also assessed as per Appendix 3.

The VIRWG recognised that it was not feasible for it to complete the development of the proposed new and amended MBS items, and that this should be undertaken by the department in consultation with all relevant stakeholders. It therefore agreed that any draft MBS items would not be included in this report.

Recommendations and rationale

The VIRWG agreed on 13 final recommendations. Only those recommendations that were supported by all VIRWG members following the consultation process were progressed as final recommendations (see Consultation and feedback review process).

The VIRWG did not reach consensus on recommendations to address a small number of outstanding issues (see Outstanding Issues) and recommended that these undergo further consideration by the MRAC.

The MRAC considered the findings and endorsed the recommendations contained in this report, at its 18th meeting on 3 March 2026.

Final recommendations

Diagnostic-only angiography services

Currently, the angiography subgroup in MBS 'Category 5 – Diagnostic Imaging Services' contains 28 items. Most of the items are categorised by:

- location (head and neck, thorax, abdomen, upper limb[s], lower limb[s], aorta and lower limb[s])
- the number of acquisition runs required (1–3, 4–6, 7–9 and 10 or more).

MBS data showed that most diagnostic angiography services fell within 1–3 services and 10 or more services.

The VIRWG proposed reducing the current set of items to 2 new items that are not location specific and only based on the number of acquisition runs:

- simple (based on a weighted average of the existing MBS items for lower acquisition runs)

  and

- complex (for 10 or more runs).

Under the proposed changes, overall MBS expenditure on vascular diagnostic services would be better targeted.[1] It is expected that the new structure would retain MBS item 59970: angiography or DSA, or both, with fluoroscopy and image acquisition, using a mobile image intensifier.

The VIRWG also recognised the need for supporting diagnostic imaging for procedural services other than vascular procedures. It acknowledged that the proposal to introduce a new set of angiography items that include only 2 general items means that diagnostic angiography items that are specific to locations in the body will no longer be available for use in conjunction with non-vascular procedures. A solution for this was beyond the scope of the VIRWG, so members recommended that the department determines the extent to which the diagnostic angiography items are used by medical practitioners who do not provide vascular services, and to take necessary steps to address any shortfalls in access to diagnostic services.

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[1] Recommendation 6 in the Taskforce's *report* (p 34) proposed the removal of current run-based tiering and anatomical classifications of DSA.

Recommendation 1

Simplify and modernise diagnostic-only angiography services by reducing the current set of items for diagnostic angiography to 2 items. Ensure that procedures sitting outside of the vascular/interventional radiology/interventional neuroradiology section of the MBS do not lose access to angiography and fluoroscopy services that are clinically necessary.

Angiography and fluoroscopy in vascular procedures

The VIRWG proposed that, for vascular procedural services for which angiography and fluoroscopy are integral, the diagnostic and procedural elements should be bundled. The MBS fee should also be increased to reflect the combined nature of the service. The fee for the bundled service would be a combination of the:[2]

- current MBS fee for the procedure (or the proposed procedural fee of a new service) and
- MBS fee for the proposed simple or complex diagnostic angiography item.

Recommendation 2

When possible, include angiography and fluoroscopy in vascular procedures.

Aftercare in procedural items

In the Medicare context, 'aftercare' refers to medical treatment that is provided to a patient after a procedure but that is still part of the overall MBS cost of that procedure. For most specialities, it is generally accepted that the provider undertaking the initial procedure is the primary care provider for the patient's hospital stay. The primary care provider is restricted from claiming MBS services during the aftercare period relevant to the procedure provided to the patient.

The VIRWG noted that there are circumstances in which the responsibility for aftercare may be shared by multiple practitioners. It considered that removing restrictions on MBS billing for aftercare for the subsequent days **after** the day of a procedure would promote more targeted and effective post-procedural care.[3]

Recommendation 3

Remove the inclusion of aftercare in MBS items for vascular, interventional radiology and interventional neuroradiology procedures.

Invasive diagnostic services

The intention to treat a patient must be the underlying principle guiding the use of invasive diagnostic imaging. The VIRWG acknowledged that diagnostic investigation alone may sometimes be clinically necessary, but it rejected the use of invasive diagnostic imaging for investigative purposes that were not a part of any intention or expectation to provide a procedural treatment to the patient.

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2 Recommendation 7 in the Taskforce's *report* (p 35) proposed the bundling of procedural items with relevant angiographic items where appropriate.

3 The regulations prohibiting payment of Medicare benefits for subsequent attendances on the same day following a surgical procedure with a schedule fee of equal to or greater than $349.95 would not be affected by this change.

Recommendation 4

On the same occasion and following a non-invasive diagnosis, invasive diagnostic vascular services should usually be provided as preparation for some form of intervention, where and when clinically appropriate.

Open and endovascular/hybrid approaches

The VIRWG found that, in some cases, the distinction between open and endovascular/hybrid approaches in terms of complexity and technical difficulty has been impacted by improvements in the technologies and clinical modalities that are used to deliver vascular services. The VIRWG supported the addition of endovascular/hybrid approaches to open vascular procedures when it is clinically appropriate and supported by evidence, and the amendment of relevant MBS items.

Recommendation 5

The approach for existing MBS items for vascular procedures should be agnostic (that is, open, endovascular or hybrid) where and when it is clinically appropriate.

Consistency of MBS fees

In keeping with Recommendation 5, the VIRWG recommended that the MBS fees for open vascular services that have recognised endovascular/hybrid equivalents be standardised to ensure that patients receiving these services receive the same Medicare benefits regardless of treatment modality.

The VIRWG recognised that this may not be possible in every case and should only apply when there is evidence supporting the clinical equivalence of the open, endovascular and hybrid approaches.

Complexity modifiers are considered in Recommendation 8.

Recommendation 6

Ensure that the MBS fees are consistent for open surgical, hybrid and endovascular treatment approaches, when this is appropriate and reasonable. A complexity modifier will be used to adjust the MBS fee for a service based on the complexity of the procedure when appropriate.

Endovascular equivalents

The VIRWG noted that the changes proposed in recommendations 5 and 6 would only apply when there was a recognised endovascular or hybrid equivalent to an open surgical procedure. When this is not the case, the current MBS items for open vascular procedures should continue to apply without change.

Recommendation 7

When an endovascular equivalent to an open surgical procedure does not exist, there will be no change to the MBS item descriptor.

Complexity modifiers

The VIRWG proposed that MBS modifier items be developed to better reflect the complexity of vascular services. The VIRWG suggested introducing special purpose items that enable a percentage increase in the MBS fee for a vascular service based on

its relative complexity compared to other equivalent services. Members considered this approach to be the least likely to add an unsustainable number of new items to the MBS. Examples of modifier items already exist on the MBS and have proven to be an effective method of compensating patients for services that incur higher costs in specific circumstances.

A complexity modifier would be an administrative item rather than a clinical one, the purpose of which would be to modify the fee of another MBS item. This distinction, and the exemption of modifier items from the Multiple Operation Rule, would need to be clearly expressed in MBS legislation and rules.

Recommendation 8

Develop complexity modifiers for procedures with additional clinical components compared to what is expected of a standard procedure.

Subheadings for interventional radiology items

The VIRWG flagged that the MBS's lack of specificity regarding IR/INR services leads to misunderstandings on the part of IR/INR practitioners. The VIRWG recognised that the most significant impact may relate to private health insurers. The current placement of IR items on the MBS may result in patients without 'vascular' coverage not being reimbursed for a range of IR procedures due to the procedures being identified as vascular-only services.[4]

Recommendation 9

MRAC endorses the following and requests that the Department consider: retaining the title of MBS 'Group T8, Subgroup 3 – Vascular' and creating a new subheading for interventional radiology items; and including neurointerventional items in MBS 'Group T8, Subgroup 7' and amending its title from 'Neurosurgical' to 'Neurosurgical and Neurointerventional'.

Consistency in terms in MBS items

The VIRWG noted that the way medical services are described in the MBS is not always consistent with accepted clinical usage. Members recommended that relevant item descriptors and explanatory notes be reviewed to ensure consistency and clarity.

Recommendation 10

Ensure that MBS item descriptors and explanatory notes describe clinical procedures using wording that is consistent with the terminology used in clinical practice.

Private patient costs

The VIRWG was mindful that changing the location of vascular services on the MBS could result in current membership rules being misinterpreted and poorly implemented by insurers and private hospitals. This could lead to higher patient costs and have a negative impact on service access.

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[4] Recommendation 39 in the Taskforce's *report* (p 74) proposed changing the title of Subgroup 3 'Vascular' in 'Group T8 – Surgical Operations' to 'Vascular, Endovascular and Interventional Radiology'.

Recommendation 11

That the Department review current private health insurance membership rules with a view to extending eligibility for vascular, endovascular, interventional radiology and interventional neuroradiology services to Bronze tier policies.

Prescribed List process

The VIRWG identified that the requirements of the Prescribed List of Medical Devices and Human Tissue Products (PL) were a key barrier to patients accessing cost-effective and affordable vascular services that require an implantable device that does not remain in the body. Despite the often-high cost of these devices, they are unlikely to meet the requirements of Part A (surgically implanted medical devices) or Part C (devices that do not meet the criteria for Part A) of the PL.

The VIRWG noted that some clinicians – including vascular surgeons – have used workarounds to ensure services can be provided to patients, such as purchasing a device for private resale to a patient. In addition, private hospitals are increasingly unable to pay for the devices that are required for a vascular procedure, and private health insurers are unwilling to bear the cost of devices not on the PL. The VIRWG recognised that Government policy limits MBS benefits to clinicians' professional services and does not include the cost of devices and consumables. It recommended a review of the processes for listing new devices on the PL, with the aim of improving service affordability and patient access.

Recommendation 12

That the Department review the inclusion or removal of new devices on the Prescribed List of Medical Devices and Human Tissue Products, considering both the funding of non-implantable devices required during vascular procedures and the funding of consumables not otherwise covered by private health insurance.

Pre-surgery MBS items

The VIRWG stressed the importance of pre-surgery exercises for patients undergoing vascular procedures. In particular, supervised exercise programs should be the primary intervention in patients with claudication, which is supported by evidence. Patient outcomes of vascular interventions may also be improved when adjuvant exercise programs are offered.

Pre-surgery exercise programs typically comprise 12 weeks of multiple visits per week. Some teaching hospitals may offer the program to patients at no cost, but most vascular patients are currently required to fund the program themselves. The 5 Medicare-subsidised allied health service visits as part of a GP Chronic Condition Management Plan for eligible patients are not sufficient to cover the full program. The VIRWG therefore supported the development and implementation of an MBS item to assist patients in this area. The VIRWG also recommended exploring options for facilitating pre-surgery exercises for eligible patients.

The VIRWG recognised that the MBS may not be the most suitable mechanism for this purpose and that a non-MBS solution may need consideration.

Recommendation 13

MRAC notes the potential benefits of pre-surgery exercises / pre-operative optimisation strategies and refers this matter to MRAC's Chronic Conditions Management Review for consideration.

Outstanding Issues

The Vascular Interventional Radiology Working Group did not reach consensus on the following issues:

1. Maintaining a separation between the MBS items for diagnostic-only services provided by Interventional Radiologists and Interventional Neuroradiologists (for services for the head, neck, and spine). Interventional Neuroradiology to have a parallel set of MBS diagnostic items that are identical to, but separate from, the revised structure for diagnostic-only items proposed in this report.

2. Amending the arrangements applying to MBS items 104 and 105[5] for initial and subsequent specialist consultations, to remove any administrative barriers to the use of these items by interventional radiologists and interventional neuroradiologists.

3. Removing restrictions that prevent interventional radiologists and interventional neuroradiologists from self-determining the need for diagnostic tests.

4. Introducing appropriate theatre banding levels for interventional radiology and interventional neuroradiology procedures.

MRAC recommends that these issues be considered as part of any relevant future review or reform processes by the Department, in consultation with relevant stakeholders.

[5] MBS item 104 is for a specialist's initial attendance at a consulting room or hospital in a single course of treatment for a referred patient.
MBS item 105 is for a specialist's subsequent attendance at a consulting room or hospital (following the initial attendance) in a single course of treatment for a referred patient.

Considerations for implementation

The VIRWG noted several issues that may affect implementation:

- the rapidly evolving clinical and technological landscape in which vascular surgery and IR/INR exist
- MBS item fees and budget
- the potential for reforming MBS items for diagnostic angiography, including diagnostic-only angiography and bundling with procedural services.

The rapidly evolving clinical and technological landscape

The VIRWG acknowledged the rapidly evolving clinical landscape in which vascular surgery and IR/INR operate, due in part to technological advancements. These changes are resulting in improved technologies and clinical modalities used to deliver vascular and IR/INR services, both in Australia and internationally. Clinical practice in vascular medicine continues to change, with the understanding of vascular diseases growing constantly and new therapeutic procedures being developed. Many factors drive the evolution of vascular medicine, including the ongoing advancement of evidence-based practice, innovations in minimally invasive techniques, and technologies that have extended such interventions beyond what may be considered traditional vascular treatment. There has been a perceptible clinical shift towards more endovascular services and less open surgery, particularly for arterial diseases.

In the future, the integration of genetic factors, use of artificial intelligence (AI) and robot-assisted procedures are expected to play a vital role in improving technical success across many settings, potentially having a profound influence on how vascular medicine is conducted.

MBS fees and budget

Many MBS claims for vascular surgery and IR/INR are currently made against existing MBS items that are not specific to the procedures provided and whose fees do not reflect the complexity or time requirement of the service.

The VIRWG understood that its recommendations would likely affect Medicare expenditure and that the department must consider the budget impact of any proposed MBS changes. Members supported reinvesting any Medicare cost savings achieved from their recommendations into the vascular/IR/INR sector, to promote service sustainability and improve patient access.

Potential for reform

Significant improvements in service effectiveness may be achieved by reforming the current set of diagnostic angiography items and bundling diagnostic angiography and fluoroscopy with a range of procedural services.

Currently, most of the angiography MBS items in ‘Category 5: Diagnostic imaging services’ are categorised by both location in the body and the number of required acquisition runs. The VIRWG recommended introducing new general diagnostic items that would only include angiography and fluoroscopy (see Recommendation 2). Other clinically necessary diagnostic modalities, such as ultrasound and computed tomography, would continue to attract Medicare rebates in line with current practice.

The VIRWG also proposed that diagnostic angiography and fluoroscopy be acknowledged as an essential component of many vascular services. These proposed reforms are in line with recommendations 6 and 7 of the MBS Review Taskforce report.

Consultation and feedback review process

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to Government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Consultation and outcomes

The VIRWG draft report was uploaded to the department's Consultation Hub, with public consultation opening on 10 September 2025 and closing on 22 October 2025. Some organisations requested and were granted extensions until 31 October 2025.

A total of 148 submissions were received. All organisations with members on the VIRWG provided written submissions. A further 13 organisations not involved with the VIRWG submitted feedback. The remaining submissions were from individuals or groups of individuals.

IR/INR practitioners and vascular surgeons disagreed significantly on several issues. Specifically, IR/INR practitioner submissions **supported** and vascular surgeon submissions **rejected** recommendations relating to:

- the removal of aftercare restrictions
- fee parity for equivalent open surgical and endovascular approaches to treatment
- reduced barriers to the use of MBS items 104 and 105 by IR/INR practitioners
- the removal of restrictions preventing IR/INR practitioners from self-determining the need for diagnostic tests.

Many of the vascular surgeon submissions also expressed strong concern that any additional allocation of MBS funding to IR/INR services would be at the expense of funding for vascular services.

Appendix 1 Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MBS Review Advisory Committee (MRAC). The Committee's role is to provide independent clinical, professional and consumer advice to Government on:

1. opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
2. the safety and efficacy of existing MBS items
3. implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health, Disability and Ageing's MRAC webpage.

MBS Continuous Review Guiding Principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
  - recognising the central role of General Practice in coordinating care
  - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
  - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need

- ensures accountability to the patient and to the Australian community (taxpayer)
- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term 'General Practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through Government announcement.

Information will also be made available on Department of Health, Disability and Ageing websites, including MBS Online, and departmental newsletters.

Appendix 2 Additional guidance for PICO assessments

PICO	Additional guidance to be incorporated if relevant to the review question(s)
Patient (who is your patient/population)	Will there be a change to the patient **population**? For example, will new **populations** under the care of different health professionals access the service?
	Will the clinical management of the **population** change? Are there flow-on effects to other areas of the health system?
	How will the clinical management of the **population** change, including changes in health resource utilisation, or assignation to therapy?
	Will the process be more or less complex for the **patient**?
Intervention (what do you plan on doing for the patient?)	For proposed new providers, is there evidence to show they have sufficient training to **provide the service**, and/or is it within their recognised scope of practice? If not, consider: • What training or qualifications would be required to perform the service? • Can these be provided through an accredited training body?
	Are the existing and proposed **provider groups** considered comparable from their registration and training?
	For the proposed **new providers**, what MBS item/s are they requesting access to and how many new **providers** (approximately) are requesting access? Would the proposed **provider group** have access to the appropriate provider number to access Medicare benefits?
	Will the fee for service be the same for the new **provider group**? Justify why the same if they have a lower level of skill, or there is a change in time to perform the service.
	Will there be any changes in how the **service is provided**, such as preparation for the **service**, time taken to provide the **service**, etc.?
	For **diagnostic services**, how do the **requestors (providers)** use the information provided by the service in their practice?

PICO	Additional guidance to be incorporated if relevant to the review question(s)
	Which **providers** can currently request / refer the service? What training or qualifications do they possess, and would these be required for new requester/referrers?
	Is this change supported by current **providers**, the professional body and relevant stakeholders (e.g. relevant peak bodies and consumer groups)?
Comparator (what alternatives are you considering?)	What is the **comparator**? Is the **comparator** the MBS service currently provided by a different profession or is it the same/similar service provided by the proposed new provider via a non-MBS mechanism or something else?
	How does the health care resource use and costs for the proposed service **compare** with the **comparator**?
Outcome (what do you wish to accomplish?)	Will there be an impact on patient **outcomes** in terms of clinical effectiveness, safety or the quality of the service being provided? Can this be quantified?
	Is there a risk of adverse **outcomes**?
	What are the flow-on effects of the **change** including costs/offsets?
	Will there be a **change** in service utilisation? Consider: • Estimated number of services which would likely be provided by the proposed new provider or item number • Whether there would be increase in uptake of existing services, or a shift in services previously provided by a different provider • Whether there would be an increase or a reduction in total services, and can these changes be quantified. • Can utilisation be broken down by state, territory and rurality?

Appendix 3 Assessment of the proposed MBS item descriptor

When considering a proposed new or amended MBS item descriptor, members are encouraged to consider whether the item descriptor:

- addresses a deficiency, or deficiencies, in the current model of care
- improves patient outcomes compared with the current model of care
- reflects a high-quality, evidence-based intervention with acceptable risk to benefit ratio
- addresses a discrete/well-defined target population
- is applicable to a defined workforce/expertise
- promotes subsidiarity
- promotes triage according to need
- integrates with a general practitioner–coordinated model of care
- does not promote perverse incentives
- has a low potential for unintended consequences
- describes a complete service
- has measurable outcomes
- does not duplicate an existing item
- where relevant, triggers a review of any relevant MBS item(s)
- does not encourage cost shifting
- is easy to interpret and implement
- does not impose a large bureaucratic burden.