
Medicare Benefits Schedule Review

Taskforce

Intensive Care and Emergency Medicine

Clinical Committee Report

Taskforce Findings

This document outlines the Medicare Benefits Schedule (MBS) Taskforce’s recommendations in response to the Intensive Care and Emergency Medicine Clinical Committee Report.

The Taskforce considered the recommendations from the Intensive Care and Emergency Medicine Clinical Committee and feedback from public consultation.

The Taskforce endorsed the recommendations from the Intensive Care and Emergency Medicine Clinical Committee, and submitted them to the Minister for Health for Government consideration.

Number of items reviewed	29
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Number of recommendations made	10
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The recommendations are intended to encourage best practice, improve patient care and safety, and ensuring that MBS services provide value for the patient and the healthcare system. This may be achieved by deleting items that are obsolete or that provide questionable clinical value or low-value care; consolidating or splitting items to address

potential misuse; modernising item descriptors to reflect best practice; and providing clinical guidance for appropriate use through explanatory notes.

List of Taskforce recommendations

Recommendation 1

Restructure ED attendance items into three tiered base items with add-ons items. – The three tiered base items reflect the differing levels of professional involvement required during emergency attendances, based on the number of differential diagnoses and comorbidities that require consideration.

– The add-on items are designed to reflect the significant additional professional involvement associated with issues or tasks that may be performed in an ED context, but that are not a standard component of any particular base item. Specifically, these items cover resuscitation (for half an hour to one hour, one to two hours, or two hours or more), anaesthesia, minor procedures, procedures, fracture / dislocation management excluding aftercare, fracture / dislocation management including aftercare, care for patients above the age of 75 or below the age of two, chemical or physical restraints, and goals of care.

– Other MBS items should not be used for services (or components of services) provided in the course of an ED attendance (i.e., services rendered by an Emergency Physician in conjunction with an ED attendance). Add-on items should be used instead of all existing MBS procedural items, such as anaesthetics items.

Recommendation 2

Use a consistent item framework for all emergency attendances, regardless of the provider type. – Item descriptions for professional attendances in accredited private EDs should specify the provider type and applicable schedule fee but should otherwise be the same, regardless of whether the item is provided by a specialist Emergency Physician, a trainee in emergency medicine, a GP (whether vocationally registered or non-vocationally registered), or another medical practitioner.

– A lower MBS benefit should apply if the provider is not a vocationally recognised Emergency Medicine Specialist (i.e., an Emergency Physician, defined by recognition as a Fellow of the ACEM). This ‘scaled access’ to emergency attendance items should provide a fixed proportion of the benefit available for services provided by Emergency Medicine Specialists.

The proposed item descriptors and explanatory notes are the same as those provided in Section 4.2 – Emergency Department attendance items, except that they also specify the provider type and applicable schedule fee. Specifically, in place of “medical practitioner who is an Emergency Physician in the practice of Emergency Medicine,” item descriptors should specify “medical practitioner who is not an Emergency Physician in the practice of Emergency Medicine”.

Recommendation 3

Leave items relating to daily management of a patient in an Intensive Care Unit (ICU; items 13870 and 13873) and invasive pressure monitoring (item 13876) unchanged.

This recommendation reflects the Committee’s view that these items are functioning as intended, and that item 13876 remains an accurate and appropriate scalable surrogate for the complexity of patients in an ICU.

Recommendation 4

Remove the differential fees for the first day (remove item 13847) and subsequent days (revise item 13848) of managing counterpulsation by intraaortic balloon.

This recommendation simplifies the MBS and is intended to enhance value for the patient and the health system, recognising that there is no significant difference in the professional involvement required between first and subsequent days of care.

Recommendation 5

Consider an expedited MSAC assessment for listing 6 new MBS items for extracorporeal life support, and revise items 13851 and 13854 to clarify that they are intended to cover ventricular assist devices (VADs).

This recommendation focuses on addressing ambiguity in the current item descriptors for items 13851 and 13854, and on supporting access to best-practice health services.

Recommendation 6

Revise the item descriptions for item 13815 (central vein catheterisation) and item 13842 (intra-arterial cannulation) to encourage ultrasound guidance where clinically appropriate. Where used, ultrasound guidance should not attract payment of benefits separate to those for items 13815 and 13842. This recommendation focuses on supporting best-practice health services and ensuring value for the patients and the community.

Recommendation 7

Introduce an MBS item for the discussion and documentation of goals of care by an Intensive Care Specialist. This service is for patients potentially nearing end of life, where alternatives to active management may be an appropriate clinical choice, and where relevant goals of care do not already exist. (See the proposed item descriptor in Section 5.6 for the appropriate clinical indications, required service components and restrictions on use for this item.)

This recommendation focuses on supporting access to best-practice decision-making services, with the aim of improving both the patient experience and enhancing value for the patient and the health system. The Committee noted that in ideal circumstances, goals of care are defined with a provider who is familiar with the patient, prior to admission to hospital or an ICU. However, if this has not occurred, it is important that patients (and, where relevant, family and carers) receive support to make informed choices prior to embarking on intensive and potentially prolonged treatment.

Recommendation 8

Remove obsolete item 14200 (relating to the practice of gastric lavage in the treatment of ingested poison) from the MBS.

Recommendation 9

Consider an expedited MSAC assessment for listing an MBS item for rapid response system / code blue attendances. This service is for attendances outside of EDs and ICUs by the medical practitioner taking overall responsibility for the patient in the course of the call or code response. It is not claimable in conjunction with ED attendance or ICU daily management items by the same provider.

This recommendation focuses on supporting access to this best-practice health service. It recognises that such attendances require a higher level of professional involvement than other referred attendances because the patient is either unstable or critically ill, and because the provider is unfamiliar with the patient and must attend immediately.

Recommendation 10

Leave items 13818, 13830, 13857 and 13881–13888 unchanged.