AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

# SUBMISSION

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# Proposed changes to MBS EEG items

**Closes 5 September 2025 — Extended to 10 September 2025**

**By email: MBSClinicalPolicy@health.gov.au**

## Response to proposed changes to MBS EEG items 11000, 11003, 11004, and 11005

The Australian Medical Association (AMA) appreciates the opportunity to provide feedback on the submission from the Australian and New Zealand Association of Neurologists (ANZAN) and the Epilepsy Society of Australia (ESA) regarding proposed changes to electroencephalography (EEG) item numbers. The AMA supports the intent of the submission and welcomes reforms that improve access, quality, and sustainability of EEG services across Australia.

The AMA emphasises the need for rebates that reflect the time, expertise, and infrastructure required to deliver high-quality diagnostic services. We also support the introduction of minimum training and qualification standards and acknowledge the importance of appropriate governance to ensure clinical justification and prevent overservicing. In supporting the proposed changes, we also call for consistent standards and equitable reimbursement across diagnostic specialties.

### 1. Current use of EEG items

The AMA understands EEG items are primarily used by neurologists, including paediatric neurologists, many of whom are AMA members. These services are typically delivered in hospital-based neurophysiology laboratories or specialist outpatient settings. EEGs are used for diagnostic clarification in epilepsy, and related neurological conditions, and are often interpreted by the referring neurologist. We also note a proportion of EEGs can be complex services, including those provided to children and to young people with autism, intellectual disability and behavioural challenges. In practice:

- referrals are made with a clearly stated clinical question
- EEGs are interpreted by credentialled neurologists with formal training in EEG
- services are compliant with current MBS requirements.

However, as noted in the submission from ANZAN and ESA, the current item descriptors — particularly for item 11000 — lack minimum technical and governance standards. The absence of requirements — such as minimum recording time, electrode placement protocols, and interpretation by qualified specialists — presents challenges for consistency and quality assurance across service

providers. The AMA supports the introduction of these standards to ensure high-quality, clinically useful recordings.

## 2. Potential gaps if changes are implemented

Clinicians have expressed concerns regarding current inequitable access to EEGs across geographic and socioeconomic groups. As a case example, there are only two metro hospitals and one regional centre in South Australia that provide EEG services for children and young people. The AMA does not anticipate a gap in access or service provision if the proposed changes are adopted. We believe the changes will:

- strengthen governance and quality assurance
- improve equity in access, particularly in regional and socioeconomically disadvantaged areas
- support sustainable service delivery by aligning rebates with actual workforce and infrastructure costs.

We note the proposed requirement for formal referrals and interpretation by accredited neurologists reflects current best practice and should not disrupt existing workflows.

## 3. Training requirements for providers using EEG items

The AMA supports the introduction of minimum training and qualification standards for both EEG neurophysiology scientists and interpreting neurologists. Our broader policy position is that diagnostic imaging services should only be claimed by appropriately credentialled professionals. We acknowledge ANZAN and ANZCNS have rigorous training pathways for adult and paediatric neurologists, including EEG interpretation. Neurophysiology scientists undergo formal education and supervised training in EEG acquisition and monitoring. These standards should be formalised within the MBS framework to ensure diagnostic quality and patient safety.

## Additional feedback

Benchmarking against stress echocardiography:

The AMA's position is that procedures should receive reimbursement commensurate with complexity and the time required to deliver the service. This is important to ensure healthcare providers are not disincentivised from offering necessary services.

We recently provided this feedback to the department regarding MBS items for pelvic ultrasounds, where the same item was used for both simple and highly complex procedures (e.g. endometriosis assessment), despite significant differences in time and expertise required. The AMA supported the creation of a dedicated item for complex gynaecological ultrasound, provided it was rebated at a rate that reflected the service's demands.

The AMA supports the proposed approach to benchmark EEG items against stress echocardiography and the view that EEG services are comparable in complexity and time investment and therefore

should not attract lower rebates. Additionally, we agree with the proposal to differentiate routine and prolonged EEGs more clearly and to ensure rebates reflect the actual service delivered.

Rebate realignment

The AMA shares the sector's concerns regarding reimbursement disparities across diagnostic specialties. EEG services require significant time, expertise and infrastructure. We believe current rebates for EEGs undervalue the service within the MBS structure, and this must be addressed, given the time, expertise and procedural complexity involved. We endorse the proposed rebate increases based upon real-world time and cost modelling. The AMA has consistently advocated for reforms that improve equitable access to diagnostic services, particularly where impacted by under-indexation and inconsistent fee structures that contribute to inequity for women and regional population groups. We therefore support this submission's emphasis on geographic and socioeconomic disparities in access to neurophysiology services.

Governance and overservicing

The AMA acknowledges concerns about self-referral but believes these can be addressed through governance safeguards such as formal referral requirements and auditability to ensure appropriate use. Referral and interpretation by the same specialist is common across many disciplines, but can be managed through effective auditing and governance safeguards. Additionally, we believe neurologists are well placed to determine the appropriateness of EEG referrals and interpretations and can be trusted to act in the best interests of their patients. In particular, in regional settings, requiring a second doctor to refer patients for EEGs — when the referral reason is best determined by a neurologist — is unreasonable and creates barriers to care.

Complementarity of EEG and MRI

The AMA disagrees with the suggestion that EEG use has declined due to increased MRI accessibility. EEG and MRI are complementary diagnostic tools, not substitutes. EEG remains crucial for detecting epileptiform activity; identifying seizure onset and propagation pathways; differentiating seizure types and epilepsy syndromes, which are for determining appropriate treatment; assessing epilepsy severity; distinguishing epileptic seizures from functional, non-epileptic events; and determining eligibility for epilepsy surgery. Other EEG abnormalities can help identify other neurological diagnoses, such as autoimmune encephalitis or encephalopathies. None of these tasks can be accomplished by MRI neuroimaging.

Support for item descriptor amendments

The AMA has previously called for the introduction of minimum technical standards and clearer item descriptors to improve consistency and quality assurance. As with previous consultations, we would like to see item structures streamlined and aligned with clinical practice. We support the proposed updates to item descriptors and explanatory notes (DN.1.24, DN.1.1, DN.1.2) to include minimum recording time, electrode placement standards, and interpretation requirements. This will improve clarity, reinforce technical standards, and promote appropriate use.

**Contact**

president@ama.com.au