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SUBMISSION

Thursday, 7 May 2026

AMA submission — Anaesthesia Relative Value Guide Review

Consultation closes April 2026

By email: MBSClinicalPolicy@health.gov.au

The Australian Medical Association (AMA) welcomes the opportunity to provide input to the Department of Health, Disability and Ageing's Anaesthesia Relative Value Guide (RVG) Review. The AMA supports clinician-led review processes aligning Medicare Benefits Schedule (MBS) items with contemporary clinical evidence and practice, improve patient outcomes, and maintain transparency and stakeholder engagement.

The department has outlined that the RVG Review is intended to ensure MBS billing of RVG items remains contemporary and, where possible, future proofed, with any changes implemented on a cost-neutral basis. The department's framework also emphasises a preference for amending existing items and explanatory notes (rather than creating additional items), with rationales to accompany proposed changes and appropriate use of service volume data (2023/24) to support modelling.

The AMA supports the RVG review as a clinician-led modernisation exercise keeping anaesthesia billing aligned with contemporary practice and supports high value care. Our approach is to prioritise improvements to item descriptors and explanatory notes, because clearer rules and guidance drive safer, more consistent claiming and reduce avoidable compliance risk for clinicians.

We support the department's commitment to a cost-neutral implementation model. Any shifts in unit values should be grounded in robust 2023–24 service volume data and redistributed transparently and fairly, consistent with the department's principles. In practice, the most credible pathway to "savings" is achieved through better item selection and clearer differentiation between less invasive/percutaneous services and open procedures, rather than reductions across the board.

Time units (Sub-group 21) sit at the centre of the RVG's design. The AMA supports reforms to the time-unit model that are coherent, minimise "cliff-edges" and perverse incentives, and remain testable against cost neutrality.

The AMA recommends the department takes sufficient time to consult with stakeholders to test technical proposals that are clinically grounded and bring improvements to the quality of care. We support a staged process enabling proper modelling, clinical input, and implementation planning, with early submissions establishing principles and later iterations adding detail as consensus and evidence mature.

The AMA's central request is that the department treat this review as a staged, coordination-led process — consistent with the review's own governance settings — so the profession can deliver technically sound, clinically grounded amendments. We envision these changes to be realised primarily through clearer descriptors and explanatory notes, and a coherent time unit model, tested against 2023–24 service volumes and implemented cost neutrally without avoidable disruption to compliance, billing systems, and informed financial consent (IFC).

The AMA is likely to be in a position to provide further item-level and model-specific detail over the forward months as we continue to engage with key stakeholders.

1. Review governance, timeframes and stakeholder engagement

The AMA supports the department's intent to place governance around this review and to use a consistent template so stakeholder feedback can be reconciled across the RVG, including cross-overs between sub-groups. We agree a structured approach is necessary given the RVG has not been reviewed in its entirety since the earlier Taskforce review work concluded in 2017.

The department should treat stakeholder submissions to this consultation as staged inputs. This means an initial submission confirming principles and priority design issues, followed by iterative, template‑based item recommendations and modelling as technical work with the ASA progresses. The AMA has been advised anaesthetic stakeholders expect their review of RVG arrangements to take about 12–18 months to finalise.

Past experience of major MBS reforms demonstrates that compressed consultation and implementation timelines increase the risk of unintended consequences, confusion across the sector (including private health insurer schedules), and reduced capacity to support informed financial consent. The consultation pack flags an indicative April 2026 timing for responses.

An initial submission can confirm principles, high-level design preferences and governance settings. Subsequent iteration should incorporate more detailed, item-level and modelling-based recommendations as consensus develops and data is tested against cost neutrality.

2. Guiding principles: clinical alignment, cost neutrality, clarity and "amend not create"

The department's broad scope and principles document sets clear expectations to:

- align RVG billing with best current anaesthetic practice and future-proof where possible
- implement on a cost-neutral basis
- redistribute any "saves" carefully (preferably within the same sub-group)
- avoid treating inappropriate billing as a redistributable "save"
- prioritise amending existing items and explanatory notes rather than creating new RVG items.

The AMA supports these principles and considers them appropriate safeguards against complexity creep and unintended impacts.

Modernisation and clinical alignment

The AMA supports updating item descriptors and explanatory notes so the RVG reflects contemporary practice and supports high-value care. In the AMA's experience, the most effective MBS reforms are clinician-led, clearly rationalised, and targeted at improving safe access while reducing low-value or ambiguous claiming pathways.

Cost neutrality with disciplined redistribution

We support cost neutrality as a stated review parameter. Where unit values shift, changes must be justified, transparent and tested against robust service-volume data (2023–24), as the department's template requires. Redistributive decisions should be explicit and should avoid shifting value in ways that inadvertently penalise safe practice in higher complexity or longer duration cases.

Clarity first (compliance and correct item selection)

The AMA considers the most credible source of any "savings" is not blunt fee reductions, but clearer rules supporting correct claiming and reduce ambiguity — particularly where less invasive/ percutaneous procedures may be incorrectly matched against open item structures. This approach aligns with the department's principle that correcting inappropriate claiming should be treated as improved compliance, not as funding to be reallocated elsewhere in the RVG.

Amend over create

We support the department's emphasis on amending existing items and explanatory notes, because additional item proliferation increases navigation burden, increases compliance risk, and creates downstream complexity for private health insurer schedules and patient communication.

3. Consultation and attendance items (T6 Sub-group 1 and related consultation settings)

The department anticipates review of T6 Sub-group 1 — Anaesthesia Consultations (17610-17690) by all groups. Consultation and attendance items are foundational for pre-anaesthesia assessment and peri-operative risk management. Consultation items and their explanatory notes must therefore be described clearly so claiming is consistent, clinically appropriate and defensible from a compliance perspective.

A practical objective for the RVG review should be to ensure consultation settings support best practice care while reducing administrative friction. Ambiguity in consultation requirements, or unnecessary complexity in thresholds, can cause inconsistent claiming behaviour and confusion for practices and patients. Clear, stable descriptors also support informed financial consent by improving certainty for patients about likely fees and rebates where anaesthetist services form part of the episode of care.

4. Time items (T10 Sub-group 21 – items 23010-24136): the central structural design question

Noting the department's request for input regarding time-unit structure efficacy and what alternative models may be preferable, the AMA broadly supports time units as a central design feature of the RVG. This approach influences remuneration across the entire anaesthesia system, and poor time-unit design can create cliff edges, distort incentives, and increase disputes about appropriate claiming.

We have consulted with anaesthetic stakeholders, who have emphasised time-unit refinement is a priority area for alignment between the Australian Society of Anaesthetists' (ASA) RVG, the AMA Fees List guidance and the MBS RVG. Stakeholders have suggested that one option for consideration is an earlier transition to smaller time increments (for example, 5-minute units from around three hours), noting the department's interest in alternative time-unit models. The AMA's position is that any such

change must be tested against cost neutrality using 2023/24 volumes and assessed for practical implementation impacts.

The AMA's approach to Sub-group 21 is principle-driven and evidence tested. Any reform should improve precision and coherence, reduce perverse incentives, and be modelled against current service volumes[1] to maintain cost neutrality at the aggregate level.

5. Therapeutic and Diagnostic services and explanatory notes (T10 Sub-group 19 and cross-overs)

The department's scope anticipates review across Sub-groups 18–26 and cross-overs between sub-groups, with a coordination exercise required to ensure fair representation for all anaesthetists billing the MBS. The AMA supports this system-wide lens. In practice, Sub-group 19 items and related explanatory notes are a frequent source of misunderstanding because they often govern additional services performed "in connection with" anaesthesia and interact with co-claim rules[2] and other tables.

The priority for Sub-group 19 and associated notes should be to reduce ambiguity and support correct item selection. This aligns with both the department's principle of amending explanatory notes rather than creating new items and the view that "savings" are more credibly derived from correct item selection and improved clarity than from value reductions.

6. Modifying units and after-hours/emergency settings (Sub-groups 22-25)

The AMA's position is that modifiers must remain clinically coherent, applied consistently and not duplicative of other parts of the RVG in ways that create unintended incentives or confusion.

Changes to modifiers should be approached cautiously and modelled for downstream effects. Modifiers often serve as the RVG's recognition of complexity and circumstance and therefore must remain aligned with clinical intent and patient safety. Any refinement should be accompanied by clear explanatory notes to prevent inconsistent interpretation across practices and billing systems.

7. Implementation considerations: sector readiness, compliance and informed financial consent

The AMA places strong weight on implementation readiness for major RVG changes, including sufficient lead time for billing system updates, private health insurer schedules, and clear patient communication to support informed financial consent.

The AMA's informed financial consent position statement emphasise patients should understand fees, Medicare rebates and private health insurance benefits, and that practitioners may need to inform patients about the likely fees of other medical practitioners (including anaesthetists) who may provide services during an episode of care. Good informed financial consent (IFC) practice is facilitated when item settings and explanatory notes are clear and stable, and when the sector has sufficient time to

[1] In this context, 'modelling' means assessing the net impact of a proposed time-unit structure using historic service counts to confirm overall neutrality and identify where redistribution would occur.
[2] In this submission, 'therapeutic and diagnostic (T&D) items' refers to additional services performed in connection with anaesthesia (for example, monitoring or procedural adjuncts) that may be claimed alongside the main anaesthesia service where eligibility criteria are met.

embed changes into billing guidance and patient communication processes. The Department should ensure RVG reforms:

- come with clear explanatory material (worked examples where appropriate) to support consistent claiming
- have implementation lead time sufficient for insurer schedule updates and billing system changes
- are staged where necessary so the sector can prepare and patient IFC is not undermined.

Contact

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