Introduction of two new long consultation items for complex gynaecological conditions

Last updated: 25 June 2025

- From 1 July 2025, two new Medicare Benefits Schedule (MBS) items will be introduced for gynaecology consultations of 45 minutes or longer, to support patients who have complex conditions such as endometriosis and pelvic pain.
- These changes are relevant for specialist gynaecologists.
- Two video items are also being introduced which mirror the face-to-face items.

What are the changes?

Effective 1 July 2025, two new MBS items will be introduced to provide gynaecological consultations of 45 minutes or more for management of complex conditions.

New MBS item 125 will be introduced for an initial attendance and new MBS item 126 will be introduced for a subsequent attendance.

New MBS video items 127 and 129 will be introduced as equivalents to items 125 and 126. More information about them can be found in the ‘New telehealth items for specialists’ fact sheet.

For private health insurance purposes, MBS items 125 and 126 will be listed under the following clinical category and procedure type:

Private Health Insurance Classification:

- Clinical category: Gynaecology
- Procedure type: Type C

Why are the changes being made?

The items will support patients with complex gynaecological conditions, including endometriosis, polycystic ovarian syndrome and pelvic pain to receive longer consultations that will allow for improved diagnosis, management and treatment of their condition. The new items were announced by Government in the 2024-25 Budget. More information about the Budget and decisions taken can be found at www.budget.gov.au.

What does this mean for providers?

Effective 1 July 2025, the new items can be claimed by patients where a specialist gynaecologist delivers a service of 45 minutes or longer and meets the item descriptor requirements. The new items are intended for consultation with patients who have been

referred to them for treatment of complex gynaecological conditions, including but not limited to endometriosis and pelvic pain.

These items should only be provided by specialists who have received a referral for the review and treatment of the patient's complex gynaecological condition.

Generally it is not expected that specialists providing assisted reproductive technology would bill these items unless they were also treating a patient's complex gynaecological condition.

How will these changes affect patients?

The changes provide an increased benefit for patients which reflects the longer consultations for patients with chronic conditions, and will support gynaecologists to discuss complex gynaecological concerns, where their consultation appointment is for a minimum of 45 minutes in duration. The items will support both initial (first) as well as subsequent consultations.

Who was consulted on the changes?

Consultation regarding these changes was undertaken with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the National Association of Specialist Obstetricians and Gynaecologists (NASOG), the Australian Medical Association (AMA), and the Royal Australian College of General Practitioners (RACGP).

How will the changes be monitored and reviewed?

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 of Health, Disability and Ageing (the department) compliance program can be found on its website at Medicare compliance.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website. You can also subscribe to future MBS updates by visiting 'Subscribe to the MBS' on the MBS Online website.

The department provides an email advice service for providers seeking advice on interpretation of MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements)*

Rules 2011 found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

New item descriptors (to take effect 1 July 2025)

Category 1 – Professional Attendances

Group A3 – Specialist attendances to which no other item applies

125

Professional attendance lasting **at least 45 minutes** at consulting rooms or hospital, by a specialist in the practice of the specialist's specialty of gynaecology, following referral of the patient to the specialist by a referring practitioner — initial attendance in a single course of treatment, if:

(a) the specialist takes a **comprehensive** history, including psychosocial history and medication review; and

(b) the specialist undertakes any of the following that are clinically relevant:

(i) a comprehensive multi-system physical examination;

(ii) consideration of multiple complex diagnoses;

(iii) discussion of all treatment options available;

(iv) assessment of pros and cons of each treatment option given patient characteristics and medical history;

(v) consideration, discussion and provision of necessary referrals for clinically appropriate investigations or treatment;

(vi) communication of a patient-centred management plan; and

(c) the specialist makes available **to the patient or carer written documentation** that outlines treatment options and information on associated risks and benefits; and

(d) another attendance on the patient did not take place on the same day by the specialist in the same single course of treatment

Fee: $178.70 **Benefit:** 75% = $134.05, 85% = $151.90

Private Health Insurance Classification:

- **Clinical category:** Gynaecology
- **Procedure type:** Type C

Category 1 – Professional Attendances

Group A3 – Specialist attendances to which no other item applies

126

Professional attendance lasting **at least 45 minutes** at consulting rooms or hospital, by a specialist in the practice of the specialist's specialty of gynaecology, following referral of the patient to the specialist by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if:

(a) the specialist takes a comprehensive history, including psychosocial history and medication review; and

(b) the specialist reviews implemented management strategies; and

(c) the specialist undertakes any of the following that are clinically relevant:

(i) update of management plan;

(ii) performance of a physical examination;

(iii) discussion of treatment options;

(iv) consideration, discussion and provision of necessary referrals;

(v) provision of appropriate education; and

(d) the specialist makes available to the patient or carer written documentation that outlines treatment options and information on associated risks and benefits; and

(e) another attendance on the patient did not take place on the same day by the specialist in the same single course of treatment

Fee: $89.40 **Benefit:** 75% = $67.05, 85% = $76.00

Private Health Insurance Classification:

- **Clinical category:** Gynaecology
- **Procedure type:** Type C

New explanatory note (to take effect 1 July 2025)

Explanatory Note AN.3.2

Items 125, 126, 127 and 129

These items are for longer consultations relating to complex gynaecological condition/s where these longer consultations are required for the appropriate assessment and management of the patient. This may include but is not limited to presentations such as chronic pelvic pain, endometriosis, polycystic ovarian syndrome or adenomyosis.

- A referral is required to use any of these attendance items.
- A separate referral is required to initiate a separate course of treatment (e.g. obstetric attendance item 16401 for obstetric management).
- A single course of treatment is defined in GN.6.16.
- If a longer initial consultation item (125 or 127) was claimed, a patient may require a 45 minute or longer subsequent attendance (item 126 or 129) or a standard subsequent attendance (item 105).
- Subsequent longer attendance items 126 or 129 can only be claimed if initial longer attendance items 125 or 127 have previously been claimed for the patient for the same course of treatment.
    - These items should only be provided by specialists who have received a referral for the review and treatment of the patient's complex gynaecological condition.
    - Generally it is not expected that specialists providing assisted reproductive technology would bill these items unless they were also treating a patient's complex gynaecological condition.

Claiming restrictions

- No other attendance items can be claimed for the same patient on the same day for the same single course of treatment.
- Routine obstetric care cannot be claimed under items 125, 126, 127 or 129.
- A pregnant patient may be referred for treatment of gynaecological issues and item 125 may be claimed.
    - Any obstetric or maternity care that the same patient requires treatment for require a separate referral and represent a separate course of treatment.

Attendance requirements and recording of clinical notes

- Only time spent with the patient should count towards the duration of the consultation. Appropriate details of services provided should be recorded. Time taken to review information before and after the consultation, such as reports or investigations, do not count toward the duration of the consultation if the patient is not present.
- The practitioner must keep adequate and contemporaneous notes to support the service provided and justification for the mode of care used.

- Clinicians should record the date, time and duration of the consultation and retain these records for a minimum of 2 years.

Patient Examinations

- As outlined in the item descriptor, comprehensive examination is only required when clinically relevant.
- An appropriate examination may be physical (when claiming face to face items 125 or 126) or may be conducted via video or with **or** without assistance from another health professional when clinically appropriate (when claiming video items 127 or 129).

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 factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.