AUSTRALIAN GENERAL PRACTICE · QUICK REFERENCE

MBS item number cheat sheet

Verified against
MBS Online
14 August 2026
Fees: **1 July 2026**

Organized by what you are doing, not by item number. One card per scenario, so the front desk finds the item by the job rather than by memory.

1	A standard consult in your rooms	Levels A–E
2	A home visit or aged care round	Derived fees
3	An after-hours consult	Time cutoffs
4	A video or phone consult	Eligibility
5	A care plan for a chronic condition	New from 2025
6	A health assessment	Four durations
7	A mental health treatment plan	Changed 2025
8	An ECG in the practice	Three items
9	Reading any item, and looking one up	Method

RE-VERIFY EVERY 1 JULY

Most MBS schedule fees are indexed on 1 July each year. The indexation factor for 1 July 2026 was 2.6%. Reprint this sheet after each July indexation, and check MBS Online before relying on any figure in a claim.

WHAT THE FEES MEAN

Every dollar figure here is the **schedule fee**, which is the reference amount the MBS attaches to the item. It is not a price you have to charge. Medicare pays a benefit calculated from it: 100% for non-referred GP attendances on non-admitted patients, 85% for most other out-of-hospital services, and 75% for services provided as part of hospital treatment.

Source: MBS Online (mbsonline.gov.au and www9.health.gov.au/mbs)

SCENARIO 1

A standard consult in your rooms

Business hours
Category 1, Group A1
Benefit **100%**

Five time tiers, in consulting rooms, during business hours. Use these when no more specific item describes the service.

ITEM	LEVEL	TIME WITH THE PATIENT	SCHEDULE FEE
3	Level A	An obvious problem, short and straightforward	**$20.55**
23	Level B	At least 6 minutes and less than 20 minutes	**$45.05**
36	Level C	At least 20 minutes	**$87.10**
44	Level D	At least 40 minutes	**$128.35**
123	Level E	At least 60 minutes	**$207.90**

RULES THAT DECIDE THE TIER

- **Only time with the patient counts.** Note-writing counts while the patient is present, and not after they leave.
- **The best-fitting item wins.** If a more specific MBS item describes the service, claim that instead of a general attendance.
- **Multiple issues are fine.** Claim one attendance for the total time, not one per problem.
- **Documentation is part of the item.** The descriptor requires appropriate, contemporaneous records.

CHECK YOUR OLD SHEET

Level E (item 123) only started on 1 November 2023. Many cheat sheets still in circulation stop at Level D, so a 60-minute consult gets under-billed.

Compiled by **Pabau**

Verified 14 August 2026 · fees as at 1 July 2026

SCENARIO 2

A home visit or aged care round

Business hours
Out of rooms and RACF
Benefit **100%**

Same five tiers, different item numbers. Out-of-rooms attendances use a derived fee rather than a flat schedule fee.

Item numbers by setting and tier, business hours.

SETTING	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E
In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124
Residential aged care	90020	90035	90043	90051	90054

RESIDENTIAL AGED CARE FEES

ITEM	LEVEL	SCHEDULE FEE
90020	Level A	**$20.55**
90035	Level B	**$45.05**
90043	Level C	**$87.10**
90051	Level D	**$128.35**
90054	Level E	**$207.90**

HOW THE DERIVED FEE WORKS

Out-of-rooms items have no flat fee. Item 24 (Level B) is the fee for item 23, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients it is item 23's fee plus $2.50 per patient. So one visit pays best per patient, and a full round pays less each. MBS Online publishes a Ready Reckoner on each of these item pages.

SCENARIO 3

An after-hours consult

Group A22
Benefit **100%**

After-hours attendances have separate item numbers and higher schedule fees. The definition of after hours depends on where you see the patient.

In consulting rooms, after hours.

ITEM	LEVEL	TIME WITH THE PATIENT	SCHEDULE FEE
5000	Level A	An obvious problem, short and straightforward	**$34.70**
5020	Level B	At least 6 minutes and less than 20 minutes	**$58.65**
5040	Level C	At least 20 minutes	**$100.55**
5060	Level D	At least 40 minutes	**$140.95**
5071	Level E	At least 60 minutes	**$239.45**

WHEN AFTER HOURS STARTS

SETTING	SATURDAY	ANY OTHER WEEKDAY	SUNDAY AND PUBLIC HOLIDAYS
In consulting rooms	Before 8am or after 1pm	Before 8am or after 8pm	All day
Out of rooms, and RACF	Before 8am or after 12 noon	Before 8am or after 6pm	All day

OTHER AFTER-HOURS ITEM NUMBERS

Both sets use derived fees, built from the equivalent in-rooms after-hours item.

SETTING	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E
Out of consulting rooms	5003	5023	5043	5063	5076
Residential aged care	5010	5028	5049	5067	5077

SCENARIO 4

A video or phone consult

Group A40
Benefit **100%**

Telehealth items mirror the in-rooms tiers at the same schedule fees. Video covers all five levels. Phone does not.

LEVEL	IN ROOMS	VIDEO	PHONE	SCHEDULE FEE
Level A	3	91790	91890	**$20.55**
Level B	23	91800	91891	**$45.05**
Level C	36	91801	91900 *	**$87.10**
Level D	44	91802	91910 *	**$128.35**
Level E	123	91920	none	**$207.90**

* Items 91900 and 91910 are available only for patients registered in MyMedicare.

BEFORE YOU CLAIM: ONE OF THESE MUST BE TRUE

- The patient is registered in **MyMedicare** and receives the service from the practice they registered with.
- You are the patient's **eligible telehealth practitioner**. You gave them a face-to-face service in the last 12 months, or your practice arranged one for them in that period.
- An **exemption** applies to the patient or to the service.

THE TRAP

A previous video or phone consult does **not** count as a face-to-face service for the 12-month test. "Eligible telehealth practitioner" is the term MBS Online adopted on 1 November 2025, replacing "established clinical relationship". The underlying test did not change.

EXEMPTIONS FROM THE ELIGIBLE-PRACTITIONER RULE

PATIENT-BASED	SERVICE-BASED
Under 12 months of age	Urgent after-hours services
Experiencing homelessness	Specified mental health treatment items
In a natural disaster affected area	Blood borne virus, sexual or reproductive health items
Seen at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service	Preparing or reviewing a GP chronic condition management plan
Isolating or quarantining under a COVID-related public health order	

RECORD IT

Where an exemption applies, document the exemption and the clinical justification in the patient's notes at the time of service.

SCENARIO 5

A care plan for a chronic condition

Group A15
Benefit **100%** out of hospital

Two items now cover a GP chronic condition management plan: one to prepare it, one to review it.

ITEM	WHAT IT COVERS	SCHEDULE FEE
965	Preparing a GP chronic condition management plan	**$160.60**
967	Reviewing a plan prepared by you or an associated medical practitioner	**$160.60**

CEASED 1 JULY 2025 — DO NOT BILL

OLD ITEM	WHAT IT WAS	REPLACED BY
721	GP management plan	965
723	Team care arrangements	965
732	Review of a GP management plan or team care arrangements	967

TELEHEALTH EQUIVALENTS EXIST

Group A40 carries video and phone subgroups for GP chronic condition management plans, so a plan does not have to be prepared face to face. Preparing or reviewing a plan is also exempt from the eligible telehealth practitioner rule.

SCENARIO 6

A health assessment

Group A14
Benefit **100%**

Four items, separated only by how long the assessment takes. The eligible patient groups are set out in the explanatory notes on each item page.

ITEM	ASSESSMENT	DURATION	SCHEDULE FEE
701	Brief	Not more than 30 minutes	**$71.00**
703	Standard	More than 30 minutes, less than 45	**$165.05**
705	Long	At least 45 minutes, less than 60	**$227.75**
707	Prolonged	At least 60 minutes	**$321.75**

WHAT EACH ITEM REQUIRES

- **701** — collection of relevant information including a patient history, a basic physical examination, interventions and referrals as indicated, and preventive health care advice.
- **703** — detailed information collection, an extensive physical examination, interventions and referrals, and a preventive health care strategy.
- **705** — comprehensive information collection, an extensive examination of medical condition and physical function, and a basic preventive health care management plan.
- **707** — as for 705, plus psychological and social function, and a comprehensive preventive health care management plan.

SCENARIO 7

A mental health treatment plan

Group A20
Benefit **100%** out of hospital

Four items cover preparing a GP mental health treatment plan. The item depends on the length, and on whether the GP has completed mental health skills training.

ITEM	DURATION	MENTAL HEALTH SKILLS TRAINING	SCHEDULE FEE
2700	At least 20 minutes, less than 40	Not completed	**$85.80**
2701	At least 40 minutes	Not completed	**$126.35**
2715	At least 20 minutes, less than 40	Completed	**$108.95**
2717	At least 40 minutes	Completed	**$160.50**

REMOVED 1 NOVEMBER 2025

The mental health treatment plan **review** items and the **mental health consultation** items came off the MBS under the Better Access Redesign. GPs and prescribed medical practitioners now use ordinary general attendance items to review a plan, refer for treatment, or provide ongoing mental health care. Items 2712 and 2713 return no result on MBS Online. If your software still offers them, its item list needs updating.

WHO PREPARES THE PLAN

From 1 November 2025, preparing a plan, referring for treatment, and reviewing a plan are linked to the patient's GP or prescribed medical practitioner at their MyMedicare practice, or to their usual medical practitioner.

SCENARIO 8

An ECG in the practice

Category 2, Group D1
Benefit **85%**

Three twelve-lead ECG items, and the difference between them is who reports on the trace. The one most general practices bill is 11714.

ITEM	WHAT IT COVERS	SCHEDULE FEE	BENEFIT
11714	Trace and clinical note, by a medical practitioner	**$29.00**	**$24.65**
11707	Trace only, sent to a specialist or consultant physician for a formal report	**$22.00**	**$18.70**
11704	Trace and formal report by a specialist or consultant physician, on request	**$37.40**	**$31.80**

ITEM 11714 CONDITIONS

The trace must be required to inform clinical decision making during or following an attendance. The clinical note must detail the clinical indication, and interpret the trace in the context of that indication. An interpretation based solely on automatically generated machine measurements or diagnoses does not meet the item. Claimable not more than twice on the same day.

WHY THE BENEFIT IS 85%

These items sit in Category 2, not Category 1, so out of hospital they attract 85% of the schedule fee rather than 100%. Co-claiming restrictions with items 12203 to 12250 and with 12218 and 12219 apply. Check the descriptor before pairing an ECG with another cardiovascular item.

SCENARIO 9

Reading any item, and looking one up

Method
Works for all 5,700+

Every MBS item page carries the same few fields. Learn them once and you can read an item you have never billed.

ANATOMY OF AN ITEM, USING ITEM 23

FIELD	WHAT ITEM 23 SAYS	WHAT IT MEANS
Item number	**23**	The code that goes on the claim
Category and group	Category 1, Group A1	A professional attendance, GP attendances where no other item applies
Descriptor	GP attendance at consulting rooms, at least 6 and less than 20 minutes	Every condition must be met before you claim
Schedule fee	$45.05	The reference fee, not a price you must charge
Benefit	100% = $45.05	Non-referred GP attendance on a non-admitted patient
Description updated	1 November 2023	Anything printed before then has the wrong wording
Schedule fee updated	1 July 2026	The figure came out of the 1 July 2026 indexation

THE FIVE THINGS THAT PICK AN ATTENDANCE ITEM

- **Practitioner type** — GP, medical practitioner who is not a GP, or prescribed medical practitioner.
- **Time with the patient** — the tier, Level A through Level E.
- **Location** — consulting rooms, out of rooms, or residential aged care facility.
- **Time of day** — business hours or after hours.
- **Mode** — face to face, video, or phone.

LOOKING ONE UP

- **Search MBS Online** at www9.health.gov.au/mbs, across all text or over item numbers only.
- **Read the whole item page**, including the benefit line and both update dates.
- **Open the explanatory notes** linked from the item. Notes AN.0.9 and AN.0.74 cover GP attendances, and AN.1.1 covers telehealth eligibility.
- **Check the patient in HPOS** using the MBS items online checker. It will not check in-hospital items or MyMedicare-linked eligibility.
- **Download the schedule** if you work offline. MBS Online publishes monthly XML files plus item map and item descriptor text files.
- **Subscribe to MBS Online news** by email or RSS. There is no official MBS app.

WHERE THE LAW SITS

MBS publications are not legal documents. Where a publication and the legislation disagree, the legislation decides what Medicare pays. The authority is the Health Insurance Act 1973, the Health Insurance Regulations 2018, the services tables made under them, and determinations under section 3C of the Act.