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Faculty of Pain Medicine
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College of Anaesthetists

16 January 2026

Specialist Services Team
Australian Government, Department of Health, Disability and Ageing
surgicalservices@health.gov.au

Dear Specialist Services Team,

MBS Continuous Review request response: MBS items 132 and 133 – Access for Specialist Pain Medicine Physicians

This letter is in relation to the email response provided by the MBS Continuous Review Team on 26 November 2025 regarding the Review Request for consideration under the MBS Continuous Review process for access to MBS items 132 and 133 for Specialist Pain Medicine Physicians (SPMPs).

The Faculty of Pain Medicine (FPM), within the Australian and New Zealand College of Anaesthetists (ANZCA) appreciates the department's consideration of the review request and acknowledgment of the constraints in MBS specialist attendance item structure. However, FPM considers there are still gaps and concerns with the current government position and would like to highlight three areas to discuss with you further.

1. **The current government position does not meet contemporary, best clinical practice, patient outcome, and high value care perspectives**

We understand that the Australian Government is currently considering options to address specialist access and affordability, however separating the difference between appropriate and uniform access to MBS items based on the clinical services provided, and specialist professional fees charged is required. Agreeing and implementing any options to specialist access will take time. What should the health sector, and FPM specifically, do in the meantime to ensure equity?

SPMPs are superspecialists who undertake two years of advanced full-time training and examination in pain medicine following their primary specialty training (such as anaesthesia, general practice, rehabilitation medicine, psychiatry, obstetrics and gynaecology or other specialties). Despite this, many SPMPs are limited to billing MBS items 2801 and 2806 for complex consultations. These items are inadequate relative to the length and complexity of chronic pain assessments and multidisciplinary care planning. While SPMPs with a physician base qualification can access consultant physician Group A4 items (132/133) i.e. holding a fellowship qualification with the Royal Australasian College of Physicians (RACP), SPMPs from anaesthesia, general practice or other pathways cannot. This means there is inequity within a single specialty and disincentivises high-value, time-based care in the community, precisely where it is needed to prevent hospital presentations, limits patient access, discourages best-practice multidisciplinary care and supports opioid stewardship.

The MBS is the only mechanism that can correct this inequity and ensure fair recognition of SPMP services.

This inequity continues when noting that Sport and Exercise Medicine Physicians (SEMPs) have been reclassified as consultant physicians with access to Group A4 (including 132/133) from 1 July 2025. SPMPs and SEMPs manage distinctly different patient populations. Chronic pain patients in specialist services present with substantially greater clinical, social and psychological complexity than the typically younger, more athletic clientele of sports and exercise medicine. Evidence consistently demonstrates that SPMPs manage patients with greater complexity than other consultant physician specialties, including SEMPs and underscores that SPMPs routinely care for some of the most complex patients in the healthcare system.

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In addition, two new long consultation items for complex gynaecological conditions (including endometriosis and pelvic pain) commenced from 1 July 2025. Both government decisions closely mirror the arguments for SPMPs: complex, longer consultations; chronic disease management; and reduced downstream costs to the health system.

2. Concerns on "using the items as intended"

FPM is concerned that the departmental response has indicated it is "not clear if the pain medicine physicians are proposing to use the items as intended" - to provide a treatment and management plan for the referring practitioner, rather than to support ongoing care. We are not sure what information has been used to inform this, especially when compared to other specialties. Further information would be useful to understand scope and usage concerns.

FPM met with the MBS compliance section in October 2025 about anomalous billing practices involving SPMPs, where it was advised there were a small number of inappropriate claims, mainly relating to timing of billings and potentially inappropriate misuse of extended care items 132 and 133. As indicated by the MBS review request, the majority of SPMPs do not have access to these item numbers so the faculty was unclear of the instances. It was advised the incidents were infrequent and isolated. Following the meeting, FPM communicated to SPMPs that this could attract more serious attention if repeated.

SPMPs would use MBS items 132 and 133 in a manner entirely consistent with their stated intent, namely, to support comprehensive assessment, formulation, and communication of a detailed treatment and management plan for the referring practitioner and other involved specialists. In pain medicine, this typically involves a once-off or episodic extended consultation to integrate complex biomedical, psychological, and social factors; review high-risk pharmacotherapy; and provide clear, structured recommendations to guide ongoing care in primary care and other specialist settings. These items would not be used to support routine follow-up or ongoing care, but rather to facilitate high-value, time-limited specialist input that improves care coordination, supports GPs, and reduces downstream system costs.

3. How can we best inform, assist or be a part of the government's next steps?

ANZCA or FPM were not part of the Specialist Costs Roundtable advised in the November 2025 email response. We understand that the Council of Presidents of Medical Colleges (CPMC) attended this roundtable on behalf of medical colleges. With this in mind, how can FPM inform or assist in the government's next steps? Perhaps this includes contributing data and clinical evidence specific to chronic pain? Or articulating the quantity of the workforce gap by the lack of MBS item access?

Thank you for your leadership on this critical issue. We would welcome the opportunity to discuss these issues with you further, including next steps.

Yours sincerely,

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