Supplement to the

Medicare Benefits Schedule

Of 1 November 2001

Effective 1 May 2002

Commonwealth Department of Health and Ageing

This book provides information on the arrangements for the payment of Medicare benefits for professional services rendered by registered medical practitioners and approved dental practitioners (oral surgeons). These arrangements operate under the Health Insurance Act 1973 (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

SUPPLEMENT TO 1 NOVEMBER 2001 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2002

This supplement provides details of changes to the 1 November 2001 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2001 Schedule.

At the time of printing, the relevant legislation giving authority for the changes included in this supplement may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny.

SAFETY NET
The Medicare "safety net" increased to $309.80 with effect from 1 January 2002 (see para 1.1 of General Explanatory Notes to the 1 November 2001 Medicare Benefits Schedule for details of the safety net).

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Enhanced Primary Care** – A.21 explanatory notes for Multidisciplinary Care Planning have been amended.
- **Case Conferences For Consultant Physicians** – introduction of new items (See notes below) and revision of A.24 explanatory notes.
- **GP attendance associated with PIP incentive payments: Diabetes** - changes to Group A18, Subgroup 2 and Group A19, Subgroup 2 to state that these items are only payable for one service in a 12-month period. Item descriptors and explanatory notes were also amended.
- **GP attendance associated with PIP incentive payments: Asthma** - changes to Group A18, Subgroup 3 and Group A19, Subgroup 3 to state that these items are only payable for one service in a 12-month period. Item descriptors and explanatory notes were also amended.

- **Sterilisation items** – 35657, 35687, 35688, 35691, 37622 and 37623 have been amended to emphasise legal requirements concerning carrying out these procedures on minors. Explanatory note T8.33 has also been replaced.
- **Cardio-thoracic** - changes have been made to the item descriptor for cardio-thoracic item 38281 and 38742 to further clarify the intent of the items. Changes have also been made to items 38215, 38218, 38220 and 38222 and new items 38225, 38228, 38231, 38234, 38237, 38240, 38243 and 38246 have been introduced. (See notes below).
- **Relative Value Guide** - following the introduction of the RVG on 1 November 2001, several item descriptions have been amended to provide clarification and several new items have been introduced. These include anaesthesia for post partum services (items 20956 - 20960) and anaesthesia for cardiac electrophysiological procedures (item 21942).
- **Management of Labour and Delivery** - increase the fee for item 16518 to $274.15 to align it with item 16515. This fee change was effective as of 1 November 2001.
- **Gynaecology** - the item descriptor for 35633 has been amended to further clarify the use of this item for hysteroscopic sterilisation.

A.21 EPC Multidisciplinary Care Planning (Items 720 to 730)
A.21.1 EPC multidisciplinary team care planning is a specific, defined approach to care planning. An EPC multidisciplinary team care plan is a written, comprehensive, longitudinal plan for the care of patients with one or more chronic conditions and complex care needs, developed and managed by a multidisciplinary team comprising the patient's GP and other health and care providers. EPC multidisciplinary care planning involves team-based management of the patient's complex care needs.
A.21.2 The development or review of an EPC multidisciplinary team care plan involves collaboration by the members of the team. Each of the members of the team must contribute to the development or review of the plan and not simply provide a service specified in the plan to the patient.

Chronic conditions and complex care needs
A.21.3 To be eligible for a Medicare rebate EPC multidisciplinary team care plans and case conferences may only be provided for patients with one or more chronic or terminal conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP.
A.21.4 A chronic medical condition is a medical condition that has been, or is likely to be, present for at least 6 months. EPC multidisciplinary team care plans and case conferences have been found to be most useful for patient's with complex

care needs, *for example*, where routine management of the condition is compounded by the presence of one or more of the following: unstable or deteriorating condition; increasing frailty and/or dependence; development of complications, including falls or incontinence; co-morbidities; significant change in social circumstances (eg death, illness or 'burnout' of carer); or two or more hospital admissions in the past six months.

Items 720 – 730: Application

A.21.5 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS NOT an in-patient of a hospital, day hospital facility, or a care recipient in a residential aged care facility.

A.21.6 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS an in-patient of a hospital or day hospital facility, and IS NOT a care recipient in a residential aged care facility.

A.21.7 Item 730 applies only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.21.8 For the purposes of items 720 to 730 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

Preparation of an EPC multidisciplinary care plan

A.21.9 For items 720, 722, 724, 726, 728 and 730 preparation of an EPC multidisciplinary team care plan means the preparation of a written plan in collaboration with all of the members of a multidisciplinary care plan team, describing the following matters:

(a) an assessment of the patient which considers their current and future health and care needs (refer to note A.21.4); and

(b) management goals with which the patient agrees; and

(c) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and

(d) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and

(e) arrangements for giving the treatment, services and care referred to in paragraph (b); and

(f) arrangements to review the plan by a day specified in the plan (if this review is to be claimed as an EPC care plan review item it must be done in collaboration with all of the other members of the EPC multidisciplinary care plan team; if the review is undertaken by the GP alone it should be claimed as a normal consultation item).

A.21.10 Preparation of the plan must also include:

(a) a meeting with the patient (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) to discuss the preparation of the plan; and

(b) telling the patient who will be included in the multidisciplinary care plan team; and

(c) collaborating with all of the other members of the multidisciplinary care plan team to identify the patient's needs, the management goals that should be documented in the plan, the ongoing care and services to be provided by each member of the team, and any other services that may be required from other health and care providers to achieve the management goals in the plan;

(d) recording the plan and the patient's agreement to the preparation of the plan; and

(e) giving copies of relevant parts of the plan to the other members of the multidisciplinary care plan team and to any other persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and

(f) offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer).

A.21.11 A multidisciplinary care plan team includes a medical practitioner and at least two other members who collaborate with the medical practitioner in the development of the plan and contribute to the implementation of the plan. Each of the members of the multidisciplinary care plan team must provide a different kind of care or service to the patient. One of the members of the team may be another medical practitioner (normally a specialist or consultant physician).

Example

Examples of persons who, for the purposes of care planning and case conferencing may be included in an EPC multidisciplinary care plan team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers; where they are contributing to the plan and not simply providing a service identified in the plan.

The involvement of a patient's carer in an EPC multidisciplinary care plan team can provide significant benefits in terms of input to the development of the plan and coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an additional member of the EPC multidisciplinary care plan team, with the patient's agreement and having regard to:

- the patient's circumstances;
- the degree of support provided by the carer for the patient; and
- the capacity of the carer to provide ongoing support to the patient and contribute to the work of the team.

Where the patient's carer is not a member of the EPC multidisciplinary care plan team, the practitioner should involve the patient's carer and provide information to the carer where appropriate and with the patient's agreement.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

A.21.12 The development or review of an EPC multidisciplinary team care plan involves collaboration between the members of the team. Collaboration should be based on communication between the members of the team, preferably either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, communication in the development or review of an EPC care plan may be by two-way exchange of e-mails or faxes.

A.21.13 In making arrangements for implementation of the plan, the medical practitioner, in collaboration with the other members of the EPC multidisciplinary care plan team, should specify the type of care to be provided and ascertain the availability of care from other providers, taking into account any care and support provided by the patient's carer and the carer's capacity to provide ongoing support. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a face-to-face meeting, telephone conversation, videoconference, or two-way exchange of e-mails or faxes.

A.21.14 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while collaboration and consultation is undertaken with the other members of the EPC multidisciplinary care plan team and formal documentation is prepared.

A.21.15 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the EPC multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur.

A.21.16 While no standard format for the care plan is mandated, practitioners should consider a recognised care-planning tool, for example those developed by the Royal Australian College of General Practitioners (RACGP) or Divisions of General Practice.

A.21.17 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.21 and A.21.22).

A.21.18 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

EPC Multidisciplinary Discharge care plans

A.21.19 For items 722 and 728 an EPC multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient with a chronic condition and complex care needs before the patient is discharged from a hospital.

A.21.20 Preparation of a discharge care plan (item 722) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner). Medical practitioners may contribute to a discharge care plan (item 728) for public in-patients.

Review of care plans

A.21.21 For item 724, review of an EPC multidisciplinary care plan means a process by which the medical practitioner who prepared the care plan, in collaboration with the other members of the EPC multidisciplinary care plan team:

(a) reviews a community care plan or discharge care plan prepared under item 720 or 722 including reviewing the matters mentioned in A.21.9; and

(b) considers whether the arrangements for treatment, service and care have been carried out; and

(c) collaborates with each of the other members of the EPC multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan; and

(d) if different arrangements need to be made, prepares a revised EPC multidisciplinary care plan, stating those arrangements.

A.21.22 The review of the plan must also include:
(e) discussing the review of the plan with the patient (and the patient's carer, where appropriate); and
(f) recording the patient's agreement to reviewing the plan; and
(g) offering a copy of relevant parts of the revised EPC multidisciplinary care plan (if any) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer), and giving copies to the other members of the EPC multidisciplinary care plan team and to any other persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan.

Contribution to EPC multidisciplinary care plans

A.21.23 For items 726 and 728, a contribution to a care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.24 Contribution to a care plan does not include preparation of an EPC multidisciplinary ***community*** care plan, a multidisciplinary discharge care plan or a care plan in a residential aged care facility, but can include contribution to a review of a care plan organised by another provider.

A.21.25 A medical practitioner's contribution to a ***community*** care plan, a discharge plan or a care plan in a residential aged care facility should involve collaboration based on two-way communication between the GP and the person organising the care plan. This communication should preferably be either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, a GP's contribution to a care plan may be by two-way exchange of e-mails or faxes.

A.21.26 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.27 For item 730, a contribution to an EPC multidisciplinary team care plan in a residential aged care facility must be at the request of the residential aged care facility. It is expected that a medical practitioner would not normally be required to contribute to an individual care plan in a residential aged care facility more than four times in a 12 month period. The medical practitioner's contribution should be documented in the care plan maintained by the residential aged care facility and a record of the contribution included in the care recipient's medical record.

General requirements

A.21.28 In circumstances where the patient's usual medical practitioner, as defined in A21.8, is not a member of the EPC multidisciplinary care plan team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).

A.21.29 Before commencing an EPC multidisciplinary team care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.30 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see paragraph 7 of the General Explanatory Notes).

Case Conferences for Consultant Physicians

A range of new items has been introduced for case conferences for consultant physicians in community settings and for discharge planning for hospital in-patients. These items are introduced to align the consultant physician case conferencing items with the items for general practitioner (GP) case conferences to improve the effectiveness of the items and make it easier for both professional groups to work together thereby ensuring better coordinated care for patients. The new items replace the existing items 801 to 815

Six new items (820, 822, 823, 825, 826 and 828) cover the organisation of, or participation in, a community case conference. A further six items (830, 832, 834, 835, 837 and 838) cover the organisation of, or participation in, a discharge case conference.

A further amendment has been made to the numbers involved in a multidisciplinary team. Where a consultant physician organises a case conference, a multidisciplinary team still requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Where a consultant physician participates in a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three.

A.24 Case Conferences by consultant physician (Items 820 to 838)

A.24.1 Items 820, 822, 823, 825, 826 and 828 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6

months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Items 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital or day hospital facility.

A.24.2 For items **830**, **832**, **834**, **835**, **837** and **838**, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items **830**, **832**, **834**, **835**, **837** and **838** are payable not more than once for each hospital admission.

A.24.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.24.4 A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

A.24.5 For the purposes of items 820, 822, 823, 830, 832 and 834 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

A24.6 For the purposes of items 825, 826, 828, 835, 837 and 838 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of three.

A.24.7 For the purposes of A.24.5 and A24.6, "formal care providers" includes:

- the patient's usual General Practitioner;
- allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist, dietician, psychologist, orthoptist, orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and
- community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

A.24.8 For items 820, 822, 823, 830, 832 and 834, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and

(b) recording the patient's or agent's agreement to the case conference; and

(c) recording the day on which the conference was held, and the times at which the conference started and ended; and

(d) recording the names of the participants; and

(e) recording the matters mentioned in A.24.4 and putting a copy of that record in the patient's medical records; and

(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and

(g) giving a copy of the summary of the conference to the patient's usual general practitioner; and

(h) discussing the outcomes of the patient or the patient's agent.

Participation in a case conference

A.24.9 For items 825, 826, 828, 835, 837 and 838, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) recording the day on which the conference was held, and the times at which the conference started and ended; and

(b) recording the matters mentioned in A.24.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

General requirements

A.24.10 The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for participating in a case conference or four care providers for organising a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.24.11 A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the

patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

A.24.12 Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;
- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

A.24.13 Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with Items 734 to 779.

A.24.14 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point 7 of the General Explanatory Notes for further details on billing procedures.

A.24.15 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.24.16 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

A.28 Completion of an annual cycle of care for patients with diabetes mellitus

New note A.28.5. Subsequent notes renumbered.

A.28.5 Use of these items is restricted to only one in a 12-month period, per patient of either A18 Subgroup 2 or A19 Subgroup 2. For example, if item 2517 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same 12-month period.

A.29 Completion of the Asthma 3+ Visit Plan (Items 2546 – 2559, 2664 - 2677)

Minimum Requirements

A.29.1 The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the requirements of the Asthma 3+Visit Plan. The Asthma initiative is for patients with moderate to severe asthma who in the opinion of the doctor could benefit from review, eg those whose asthma management could be improved. At a minimum the Asthma 3+ Visit Plan must include:

- At least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum)for a patient with **moderate to severe** asthma,
- Planned recalls for at least two of these consultations,
- Documented diagnosis and assessment of severity,
- Review of the patient's use of asthma related medication,
- Provision of a written asthma action plan and self-management education to the patient. (If the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record.) and
- Review of asthma action plan.

The Asthma 3+Visit Plan should be provided to a patient by one GP or in exceptional circumstances by another GP within the same practice. In most cases, this will be the patient's usual medical practitioner. Completion of the Asthma 3+ Visit Plan does not preclude referral to a specialist, although a specialist consultation cannot be counted as one of the three visits.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient held written action plan.

These items will only be payable for the completion of one Asthma 3+ Visit Plan for each eligible patient per year, unless a further plan is clinically indicated by exceptional circumstances.

If a subsequent plan is indicated and the incentive item is to be claimed more than once per year for a patient, then the patient's invoice or Medicare voucher should be annotated to indicate that the Asthma 3+ Visit Plan was required to be provided within 12 months of another Asthma 3+ Visit Plan.

Assessment of Severity

A.29.2 Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR

- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

A.29.3 Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. The website address is:

www.NationalAsthma.org.au

A.29.4 Asthma 3+ Visit Plan

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma 3+ Visit Plan as per A29.1

The minimum requirements of the Asthma 3+ Visit Plan may be carried out in 3, 4 or more visits as clinically required. The NAC recommendations below provide a guide for how the Asthma 3+ Visit Plan can be completed in 4 visits.

The visit that completes the Asthma 3+ Visit Plan should be billed using the appropriate item listed in Group A18 and Group A19 under Category 1- Professional Attendances. This will initiate the payment of an incentive through the Practice Incentives Program (PIP) in addition to attracting a Medicare rebate.

The National Asthma Council recommendations for their 3+ Visit Plan are as follows:
(NOTE: This is provided as a guide only and each case should be addressed on the patient's individual clinical needs)

Visit 1
This will often be a visit at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation.

- Manage the issue that caused asthma to be discussed, eg worsening asthma symptoms, request for a script
- Introduce the concept of a 'contract' for care: the 3+ Visit Plan and the reasons for review
- If the patient presents solely for an asthma-related problem, or it is clinically appropriate and possible, include the items in Visit 2.
- Give 3+ Visit Plan handout to patient.

Visit 2

- New patient: ascertain status, including history, medication and management.
- Existing patient: assess present situation, including review of medical records and consolidation/collection of information on history, medication and management.
- What do they know and what do they need to know? (knowledge)
- How do they feel about their asthma? (perception)
- What do they want from you, the GP?
- Review medication devices technique.
- Perform physical examination (including spirometry).
- Grade asthma severity and level of control.
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting.
- Is a change in medication required?

Visit 3 (approximately 2 weeks later)

- Review patient and his/her PEFR record.
- Perform spirometry (if not already done, or consider redoing).
- Complete written Asthma Action Plan. (Advice on content is available in the current edition of the National Asthma Council's *Asthma Management Handbook*.)
- Further identify trigger factors: consider RAST, skin-prick tests (if not already done).
- Is a change in medication required?
- Check on, reinforce and expand education.

Visit 4 (approximately 4 weeks later)

- Assess progress.
- Review Asthma Action Plan.
- Discuss results of trigger factor tests (if applicable).
- Check on, reinforce and expand education.

Source - National Asthma Council
http://www.nationalasthma.org.au/publications/3plusplan/3+visit_doctor_form_pr.html

A.29.5 From 1 November 2001, PIP Asthma 3+ Visit Plan incentive payments will be available for completing the minimum requirements of the Asthma 3+ Visit Plan as specified in clause A.29.1 above. This incentive will be paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. The Health Insurance Commission will contact PIP practices to provide information about the incentive and arrange payment details.

T8.33 Sterilisation of Minors - Legal Requirements (Items 35657, 35687, 35688, 35691, 37622, 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures.

(iv) Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973.*

Cardio-thoracic changes

Several changes have been made to the cardio-thoracic area of the Medicare Benefits Schedule. New items have been introduced (items 38225, 38228, 38231, 38234, 38237 and 38240). These new items describe the combinations of services that can be claimed under existing angiography items 38215, 38218, 38220 and 38222. This was to address the decrease in Medicare benefits that resulted when multiple items were claimed in the range 38215 - 38222, due to the application of the multiple operation rule.

An additional item, 38243, provides for placement of catheters and injection of opaque material prior to any coronary interventional procedure, including where the latter is performed by a second practitioner.

As well, item 38246 has been introduced where the same practitioner performs diagnostic coronary angiography and then the coronary interventional procedure on the same occasion.

T8.35 Selective Coronary Angiography (items 38215-38246)

T8.35.1 Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T8.35.2 Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

T8.35.3 Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231,38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

RELATIVE VALUE GUIDE FOR ANAESTHESIA (Group T10)

For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost neutral framework, as the basis for calculating Medicare benefits for anaesthesia services. This follows a feasibility study commissioned by the Commonwealth and guided jointly with the profession and extensive consultation with representatives of the Australian Society of Anaesthetists, the Australian Medical Association and the Rural Doctors Association of Australia.

Prior to the introduction of the RVG on 1 November 2001, the Schedule fee for anaesthesia was established by reference to the anaesthesia base ("B") and average time ("T") units allocated to the associated procedure. For example:

30409	LIVER BIOPSY, percutaneous (**Anaes: 17706 = 4B + 2T**)

These anaesthesia unit values listed against medical/surgical/diagnostic and Oral & Maxillofacial services in the 1 November 2000 Medicare Benefits Schedule, no longer apply. From 1 November 2001, the Schedule fee for anaesthesia is established using the RVG Schedule.

T10.1 Overview of the RVG

T10.1.1 The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) *when performed in association with the administration of anaesthesia* (see Note T10.7). These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances (see point T10.8). These items are listed at subgroup 26.

T10.1.2 Details of the RVG are available at the following website address which also includes a section answering "frequently asked questions" about the new arrangements: www.health.gov.au/haf/rvg/index.htm

T10.1.3 The RVG is based on an anaesthesia unit system reflecting the difficulty of the service and the total time taken for the service. Each unit has been assigned a dollar value.

T10.1.4 Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

(a) the **basic** units allocated to each anaesthetic procedure, reflecting the degree of difficulty of the procedure (an item in the range 20100-21997), for example:

20702	**INITIATION AND MANAGEMENT OF ANAESTHESIA** for percutaneous liver biopsy (4 basic units) Fee: $68.60 Benefit: 75% $51.45 85% $58.35

(b) the **time** unit allocation reflecting the **total time** of the anaesthesia (an item in the range 23010-24136), for example;

23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45 Benefit: 75%= $38.60 85% = $43.75

plus, where appropriate

(c) **modifying units** recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** where the patient's age is less than 12 months, or 70 years or greater (1 unit) Fee: $17.15 Benefit: 75% $12.90 85% $14.60

T10.1.5 Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients **Derived Fee**: An amount of $85.75 (5 basic units) Plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020

T10.1.6 As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate ie:

(a) the **basic** units allocated to whole body perfusion under item 22060; plus

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heart-lung machine or equivalent (20 basic units) *(See para T10.9 of explanatory notes to this Category)* **Fee:** $343.00 **Benefit:** 75% = $257.25 85% = $291.55

(b) the **time** unit allocation reflecting the total time of the perfusion (an item in the range 23010 – 24136), for example:

23033	41 MINUTES TO 45 MINUTES (3 basic units) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75

plus, where appropriate

(c) **modifying units** recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example:

I 25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** **-** where the patient's age is less than twelve months, or 70 years or greater (1 basic units) **Fee:** $17.15 **Benefit:** 75% = $12.90 85% = $14.60

T10.2 Eligible Services

T10.2.1 With some exceptions (see note T10.13), a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, an "eligible" service is defined as a clinically relevant professional service (as outlined in paragraph 1.1.4 of the General Explanatory Notes of the Medicare Benefits Schedule) which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

T10.3 RVG Unit Values

Basic Units

T10.3.1 The RVG basic unit allocation represents the degree of difficulty of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

T10.3.2 The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- ***for anaesthesia***, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- ***for assistance at anaesthesia***, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- ***for perfusion***, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

T10.3.3 For up to and including the first 4 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 4 hours, each time unit equates to 10 minutes (or part thereof).

T10.3.4 For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments.

For example:

	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME - for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service		
23010	- 15 MINUTES OR LESS (1 unit) Fee: $17.15	Benefit: 75%= $12.90	Benefit: 85% = $14.60
23021	- 16 MINUTES TO 20 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23022	- 21 MINUTES to 25 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20

23023	- 26 MINUTES to 30 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23031	- 31 MINUTES to 35 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23032	- 36 MINUTES to 40 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75

T10.3.5 For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 – 25050)

T10.3.6 Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- ***ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000)***. This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

- ***ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item*** 25005***)***. This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
  - severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
  - severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

- ***ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010)***. This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2.

Some examples of ASA 2 would include:

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle."

- ***Where the patient's age is less than 12 months, or 70 years or greater (item 25015).***
- ***For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).***
- ***For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).***
- ***For a perfusion service in association with *after hours emergency surgery (item 25050).***

*** NOTE: It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.**

NOTE: Modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item *22060*.

Definition of Emergency

T10.3.7 For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as being where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

T10.3.8 For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies see point T10.4.2.

T10.4 Deriving the Schedule Fee under the RVG

T10.4.1 The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule was derived by applying the unit value to the total number of anaesthesia units for each component. For example:

Item	**Description**		**Schedule Fee**
17603	Pre-anaesthesia Consultation		$33.40
RVG	**Anaesthesia Service**	**Units**	**Schedule Fee (Units x $17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$102.90
23190	Time – 4 hours 30minutes	19	$325.85
25000	Modifier - Physical status	1	$ 17.15
22012	Central Venous Pressure Monitoring	3	$ 51.45

T10.4.2 After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

Item	**Description**	**Units**	**Schedule Fee (Units X $17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$102.90
23190	Time – 4 hours 30minutes	19	$325.85
25000	Modifier - Physical status	1	$ 17.15
22012	Central Venous Pressure Monitoring	3	$ 51.45
	Total Units =	29	Schedule fee = $497.35
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $497.35 x 50% = $248.70

T10.4.3 Definition of Radical Surgery

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems.

T10.4.4 Multiple Anaesthesia Services

T10.4.4.1 Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

Item	Description	Units	Schedule Fee
20790	Anaesthesia for Cholecystectomy	7	$137.20
20752	Incisional Hernia	0	$ 0.00
23100	Time – 2hrs 30mins	10	$171.50
25015	Physical Status – Over 70	1	$ 17.15

T10.4.5 Prolonged Anaesthesia

T10.4.5.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T10.5 Account Requirements

T10.5.1 Before benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule are required on the anaesthetist's account:

- the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. As well, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- The perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T10.6 General Information

T10.6.1 The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

T10.6.2 Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

T10.6.3 Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.7).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

T10.6.4 The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.8)

T10.6.5 Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T10.6.6 When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.

T10.6.7 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.
T10.6.8 It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.
T10.6.9 The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

T10.7 Additional Services performed in connection with Anaesthesia– Subgroup 19
T10.7.1 Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).
T10.7.2 These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055–22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.
T10.7.3 Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

T10.8 Assistance in the Administration of Anaesthesia (Items 25200 and 25205)
T10.8.1 The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T10.8.2 **Assistance at anaesthesia in connection with emergency treatment (Item 25200)**
Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death.
Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.
T10.8.3 **Assistance in the administration of elective anaesthesia (Item 25205)**
T10.8.4 A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T10.8.5 For the purposes of Item 25205, a "complex paediatric case" involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(iv) separation of conjoint twins.

T10.9 Perfusion Services (Items 22055-22075)
T10.9.1 Perfusion services covered by items 22055-22075 have been included in the RVG format.
T10.9.2 The "Time" component for item ***22060*** is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.
T10.9.3 Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10. The service must be performed by a medical practitioner in order to attract Medicare benefits. The "on behalf of" provisions do not apply.
T10.9.4 Medicare benefit is payable where the perfusionist provides a clinically necessary service/s from Group T10, Subgroup 19 in addition to the perfusion service.

T10.10 Anaesthesia as a therapeutic procedure (Item 21965)
T10.10.1 Claims under this item should be submitted to Medicare for approval of benefits and should contain full clinical details of the service. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule.)

T10.11 Discontinued Surgery (Item 21990)
T10.11.1 Claims for benefits under Item 21990 should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T10.12 Anaesthesia in connection with a procedure not identified as attracting a Medicare benefit for anaesthesia (Item 21997)

T10.12.1 Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule.)

T10.13 Anaesthesia in connection with a dental service (Items 22900 and 22905)

T10.13.1 Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule ie removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an "eligible" service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

T10.14 Anaesthesia in connection with cleft lip and cleft palate repair (Items 20102 and 20172)

T10.14.1 Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

T10.15 Anaesthesia in connection with an Oral and MaxillofaciaI service (Category 4 of the Medicare Benefits Schedule)

T10.15.1 Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG (see point OC.4 in Category 4 of the Medicare Benefits Schedule). Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T10.16 Peri-operative blocks for post operative pain (Items 22030 to 22050)

T10.16.1 Benefits are only payable for peri-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22030 to 22050.

T10.17 Anaesthesia in connection with extensive surgery on facial bones(20192)

T10.17.1 The term "extensive" in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

T10.18 Introduction of a Narcotic (Item 22030)

T10.18.1 Benefits are attracted for this procedure irrespective of the stage of the operation at which the narcotic is introduced.

T10.19 Epidural Injection for Control of Post-operative Pain (Item 22035)

T10.19.1 This item provides benefit for the epidural injection of a local anaesthetic in the caudal, lumbar or thoracic region administered towards the end of an operation for the purposes of controlling pain in the post-operative period.

T10.20 Regional or Field Nerve Blocks for Post-operative Pain (Items 22040 - 22050)

T10.20.1 Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

T10.21 Anaesthesia for radical procedures on the chest wall (Item 20474)

T10.21.1 Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

T10.22 Anaesthesia for extensive spine or spinal cord procedures (Item 20670)

T10.22.1 This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

T10.23 Anaesthesia for femoral artery embolectomy (Item 21274)

T10.23.1 Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

T10.24 Anaesthesia for cardiac catheterisation (Item 21941)

T10.24.1 Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

T10.25 Anaesthesia for 2 dimensional real time transoesophageal echocardiography (Item 21936)

T10.25.1 Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

T10.26 Anaesthesia for services on the upper and lower abdomen (subgroups 6 and7)

T10.26.1 Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the colon;
- surgery on the appendix; or

surgery associated with the female reproductive system.

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

The regulations covering diagnostic imaging services have been amended. As a result, some of the Explanatory Notes in the 1 November 2001 MBS are outdated. The paragraphs below should replace those in the previous book.

DIH.1.1 Cardiac Ultrasound

Restrictions preventing the payment of transthoracic and transoesophageal ultrasound performed on the same day have been removed by amending items 55113, 55114, 55115, 55116, 55117 and 55118

DIH.3 Musculoskeletal (items 55800 to 55854)

All references to the musculoskeletal ultrasound items in DIH3.1.to DIH.3.4 include items 55800 to 55854.

DIH.5 Investigations of vascular disease (Items 55238 to 55296)

Multiple Vascular Ultrasound Services Site Rule

To more appropriately remunerate vascular ultrasound services under the MBS, a fee discounting model will apply for multiple site scans from 1 May 2002. This fee discounting model will be applied through the application of the Multiple Vascular Ultrasound Services Site Rule (MVUSSR). The introduction of this new rule will be accompanied by a restructure of the existing vascular ultrasound items. These include the deletion of specific multiple scan vascular ultrasound items, as these will no longer be required, and a revision of Schedule fee levels.

The vascular ultrasound services must be performed by or on behalf of a medical practitioner.

Medicare benefits will only be paid for two vascular ultrasound studies within the same working week. A study may include one or more items.

For the calculation of the Medicare benefits payable for vascular ultrasound items the following formula will apply:

100% for the item with the greatest Schedule fee
plus 60% for the item with the next greatest Schedule fee
plus 50% for each other item.

Application of the MVUSSR – examples of clinical scenarios

Example 1: When a patient is referred for a bilateral vascular service of both legs/both arms, the first service is rebated at 100% of the schedule fee, the second service is rebated at 60% of the schedule fee.

Example 2: When a patient is referred for two vascular services (eg carotid duplex and lower limb DVT) the first service is rebated at 100% of the schedule fee, the second service is rebated at 60% of the schedule fee.

Example 3: When a patient is referred for a series of vascular services (eg carotid duplex, single lower limb DVT and upper limb arteries) the first service is rebated at 100% of the schedule fee, the second service is rebated at 60% of the schedule fee. Further services will be rebated at 50% of the schedule fee.

Example 4: When a patient is referred for venous and arterial services of the one region/limb, only a single item can be claimed for that one limb. **The MVUSSR does not apply**. The medical practitioner claiming the Medicare benefit must indicate the side to be studied.

Note: the MVUSSR will apply to all vascular ultrasound items claimed on the same day of service ie whether performed at the same time or at different times.

Separation of services on the one day/contiguous and non-contiguous body areas

These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

Items 11603,11606, 11609 and 11612 – Examination of peripheral vessels

Vascular ultrasound services can continue to be claimed in conjunction with items 11603,11606, 11609 and 11612.

DIH.5.1 Deleted items

The following nine vascular ultrasound items have been deleted: 55256, 55262, 55264, 55266, 55270, 55277, 55279, 55288 and 55290.

DIH.5.3 Revised fees for vascular ultrasound items (55238 to 55296)

Effective 1 May 2002, the Schedule fee for vascular ultrasound items 55238 to 55294 has been reduced to $155.25. Item 55296 remains at $101.70. The Schedule fee includes components for interpretation of the results and provision of the report.

DIH.5.4 Amended items

Time restrictions in items 55276 and 55278 have been removed.

DIH.7 Sonographer Accreditation

From 1 November 2001, sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by the Health Insurance Commission. For further information, please contact the Department on (02) 6289 7727 or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at http://www.asar.com.au.

DIH.7.1 Eligibility for registration

In general, to be eligible for registration, the person must:
- hold an accredited postgraduate qualification in medical ultrasound;
- be studying ultrasound;
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand. (conditions apply*)

* For assessment of eligibility status, please contact the Australasian Sonographer Accreditation Registry.

DIH.7.2 Reporting requirements

The sonographer's initial and surname is to be held on the report that is kept at the practice. The name of the sonographer is not required to be included on the copy of the report given to the patient.

For the purpose of this rule, the "name" means the sonographer's initial and surname.

DIH.13 Referral forms from practitioners who have non-metropolitan obstetric privileges

Where a practitioner who has obstetric privileges at a non-metropolitan hospital refers for items 55712, 55721,55728, 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

DIL. MAGNETIC RESONANCE IMAGING

DIL. 4 Eligible Services

Group I5 items, apply only to an MRI or MRA service performed:

(a) on referral by a recognised specialist or consultant physician, where the request for the scan specifically identifies in writing the clinical indication for the scan;
(b) under the professional supervision of an eligible provider; and
(c) with eligible equipment.

Please note that the definition of eligible providers and eligible equipment has been amended as detailed below. These definitions of eligibility are the same as those that were in place prior to 1 July 2001.

DIL.7 Eligible providers

In group I5, an eligible provider is a specialist in diagnostic radiology who satisfies the Health Insurance Commission (HIC) that:
(a) he or she is a participant in the Royal Australian and New Zealand College of Radiologists' Quality and Accreditation Program; and
(b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment.

DIL.8 Eligible equipment

An eligible service must be provided within a medical practice, or the radiology department of a hospital, that offers a comprehensive range of alternative diagnostic imaging procedures. A minimum of diagnostic x-ray, ultrasound and computed tomography (CT) is needed to meet this requirement.

As from 1 November 1999, for a medical practice or hospital located in a metropolitan area, the equipment must:

(a) have been installed in a medical practice, or hospital, in Australia before 7.30pm on 12 May 1998, Eastern Standard Time; or
(b) if uninstalled at the time on that day – have been purchased or leased under a contract, in writing (that did not contain an option to cancel), before 10 February 1998;
(c) be replacement equipment for equipment mentioned in paragraph (a) or (b); or
(d) be a unit granted eligibility under the "MRI Additional Units Eligibility Scheme".

There is an exemption to protect patients requiring MRI scans in non-metropolitan areas. For a medical practice or hospital located in a non-metropolitan area:

(a) the equipment must have been installed in a medical practice, or hospital, in Australia before 7.30pm on 12 May 1998, Eastern Standard Time; or
(b) if the equipment was uninstalled at the time and on the day mentioned in paragraph (a) – it must:
    (i) have been purchased or leased under a contract, in writing (that did not contain an option to cancel) before that time on that day; and
    (ii) on or before 18 October 1999 – be in use for services for which a Medicare benefit is claimed;
(c) be replacement equipment for equipment mentioned in paragraph (a) or (b).

Irrespective of locations:
- The Commission must have been given on or before 11 October 1999 a statutory declaration in relation to the equipment, and (if the unit was not installed by 7.30pm on 12 May 1998, Eastern Standard Time) a copy of the contract, as required by the regulations; and
- Once equipment is replaced the original equipment ceases to be eligible equipment.

Metropolitan area includes any location within any of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin, or Canberra major statistical divisions, as defined in the Australian Standard Geographic Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999).

Information about eligible MRI sites or eligibility requirements may be obtained from the Provider Liaison Section at the Health Insurance Commission on 132 150.

DIL.9 Eligible Provider Declaration

The specialist must give the HIC a statutory declaration:
(a) stating that he or she is enrolled in the RACR Quality and Accreditation Program;
(b) specifying the location of the MRI equipment;
(c) specifying the kinds of diagnostic imaging procedures offered at that location;
(d) stating the date of installation of the equipment (and time of installation if this occurred on the 12 May 1998); and
(e) if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give the HIC a copy of the contract for the purchase or lease of the equipment.

In addition, the HIC may request further supporting documentation of information. Specialists are advised to contact the Provider Liaison Section at the Health Insurance Commission on 132 150 prior to lodging a declaration.

SUMMARY OF CHANGES – PATHOLOGY SERVICES TABLE

General chemistry item 66500 has had the reference to electrophoresis removed as the test is already covered under a number of other items

Drugs of abuse item 66626 has been amended to allow for 36 tests in a 12 month period

PSA item 66655 has had the requirement for 'clinically suspected prostatic disease' removed

Faeces culture item 69345 has been amended to include '….separately identified specimens, collected at different times…' to remove ambiguity

Serial dilution testing has been removed from HCG pregnancy item 73527

A new complexity level for 'Small bowel - biopsy, all sites (complexity 4)' has been included

Items 65139 (Quantitation of plasminogen) and 65140 (Quantitation of euglobulin clot lysis time) have been removed

The following are new explanatory notes:

PP.8 Blood Grouping (Item 65096)

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

PP.9 Iron Studies (Item 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

PP.10 Glycosylated haemoglobin (Item 66551)

The requirement of "established diabetes" in this item may be satisfied by:
a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or
b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or
c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

SUMMARY OF CHANGES

The 1 May 2002 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number: -

(a)	new item	†
(b)	amended description	‡
(c)	fee amended	+
(d)	item number change	*

New Items

820	822	823	825	826	828	830	832	834	835	837	838
20956	20958	20960	21942	38225	38228	38231	38234	38237	38240	38243	38246

Deleted Items

801	803	805	807	809	811	813	815	55256	55262	55264	55266
55270	55277	55279	55288	55290	65139	65140					

Amended Description

2517	2546	2552	2558	2620	2664	2666	2668	2673	2675	2677	11601
13020	20192	20300	20403	20420	20520	20940	20943	21402	21941	22012	25015
35633	35657	35687	35688	35691	37604	37616	37619	37622	37623	38215	38218
38220	38222	38281	38742	55113	55114	55115	55116	55117	55118	66500	66626
66655	69345	73527									

Fee Amended

16518	21170	21884	22060	25030	55238	55244	55246	55248	55252	55274	55276
55278	55280	55282	55284	55292	55294						

Item Number Change

Old	New	Old	New	Old	New	Old	New
801	822	803	823	805	826	807	828
809	832	811	834	813	837	815	838

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where the description, item number or Schedule fee for an item has been amended the following rule will apply:-

If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 2002 and continues beyond that date, the old (1 November 2001) item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

ATTENDANCES

GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES

Subgroup 2 - Case Conferences

820 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$110.00
822 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$165.00
823 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$220.00
825 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and to coordinate the conference) of a least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see a24.7 on permissible combinations)	$79.00
826 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$126.00
828 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$173.00
830 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$110.00

832 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$165.00
834 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$220.00
835 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$79.00
837 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$126.00
838 Note A.24	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note a24.7 on permissible combinations)	$173.00

GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS

Subgroup 2 - Completion Of An Annual Cycle Of Care For Patients With Diabetes Mellitus

2517	The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are: - Assess diabetes control by measuring HbA_{1c} At least once per year - Ensure that a comprehensive eye examination is carried out: At least once every two years- Measure weight and height and calculate bmi: At least once every six months-Examine feet: At least once every six months - Measure total cholesterol, triglycerides and hdl cholesterol: At least once every year- Test for microalbuminuria: At least once per year- Provide self-care eduaction: Patient education regarding diabetes management-Review diet: Reinforce information about appropriate dietary choices Review levels of physical activity: Reinforce information about appropriate levels of physical activity Check smoking staus: Encourage cessation of smoking (if relevant) review of medication: medication review level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; and which completes the requirements for a full year of care of a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms)	$28.75

Subgroup 3 - Completion Of The Asthma 3+ Visit Plan

2546 Note A.29	At a minimum the Asthma 3+ Visit Plan must include: - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - planned recalls for at least two of these consultations - documented diagnosis and assessment of severity - review of the patient's use of asthma related medication - provision of a written asthma action plan and self-management education to the patient - review of asthma action plan level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of the Asthma 3+ Visit Plan. surgery consultation (Professional attendance at consulting rooms)	$28.75
2552 Note A.29	Level 'c' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of the Asthma 3+ Visit Plan.surgery consultation (Professional attendance at consulting rooms)	$54.60

2558 Note A.29	Level 'd' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan and which completes the minimum requirements of the Asthma 3+ Visit Plan.surgery consultation (Professional attendance at consulting rooms)	$80.40

GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES

Subgroup 2 - Completion Of An Annual Cycle Of Care For Patients With Diabetes Mellitus

2620	The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are:-Assess diabetes control by measuring Hba1c At least once per year-Ensure that a comprehensive eye examination is carried out: At least once every two years Measure weight and height and calculate bmi: At least once every six months-Examine feet: At least once every six months- Measure total cholesterol, triglycerides and hdl cholesterol: At least once every year- Test for microalbuminuria: At least once per year- Provide self-care education: Patient education regarding diabetes management- Review diet: Reinforce information about appropriate dietary choices- Review levels of physical activity: Reinforce information about appropriate levels of physical activity- Check smoking status: Encourage cessation of smoking (if relevant) review of medication: medication review surgery consultations (Professional attendance at consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	$21.00

Subgroup 3 - Completion Of The Asthma 3+ Visit Plan

2664 Note A.29	At a minimum the Asthma 3+ Visit Plan must include: - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - planned recalls for at least two of these consultations to have planned recalls - documented diagnosis and assessment of severity - review of the patient's use of asthma related medication - provision of a written asthma action plan and self-management education to the patient - review of asthma action plan surgery consultations (Professional attendance at consulting rooms) standard consultations of more than 5 minutes duration but not more than 25 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	$21.00
2666	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	$38.00
2668	Prolonged consultation of more than 45 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	$61.00

2673	Out-of-surgery consultations (Professional attendance at a place other than the consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	Derived fee
2675	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	Derived fee
2677	Prolonged consultation of more than 45 minutes duration and which completes the minimum requirements of the Asthma 3+ Visit Plan.	Derived fee

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

Subgroup 5 - Vascular

11601	Blood pressure monitoring (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) (Anaes.)	$54.80

THERAPEUTIC PROCEDURES

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

Subgroup 1 - Hyperbaric Oxygen Therapy

13020	Hyperbaric oxygen therapy, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance	$204.70

GROUP T4 - OBSTETRICS

16518	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery	$274.15

GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

Subgroup 1 - Head

20192 Note T10.17	Initiation of management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction)	$171.50

Subgroup 2 - Neck

20300	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies	$85.75

Subgroup 3 - Thorax

20403	Initiation of management of anaesthesia for removal of breast lump or for breast segmentectomy where axillary node dissection is performed	$85.75
20420	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies	$85.75

Subgroup 4 - Intrathoracic

20520	Initiation of management of anaesthesia for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies	$102.90

Subgroup 8 - Perineum

20940	Initiation of management of anaesthesia for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies	$51.45
20943	Initiation of management of anaesthesia for transvaginal assisted reproductive services	$68.60

20956	Initiation of management of anaesthesia for evacuation of retained products of conception, as a complication of confinement	$68.60
20958	Initiation of management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery	$85.75
20960	Initiation of management of anaesthesia for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls)	$120.05
	Subgroup 9 - Pelvis (Except Hip)	
21170	Initiation of management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint	$137.20
	Subgroup 11 - Knee And Popliteal Area	
21402	Initiation of management of anaesthesia for knee replacement	$120.05
	Subgroup 16 - Anaesthesia For Burns	
21884	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface	$257.25
	Subgroup 17 - Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures	
21941 Note T10.24	Initiation of management of anaesthesia for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker	$120.05
21942	Initiation of management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation	$171.50
	Subgroup 19 - Therapeutic And Diagnostic Services	
22012 Note T10.1 Note T10.7	Blood pressure monitoring (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in association with the administration of anaesthesia	$51.45
22060 Note T10.1 Note T10.3 Note T10.9	Whole body perfusion, cardiac bypass, using heart-lung machine or equivalent	$343.00
	Subgroup 23 - Anaesthesia/Perfusion Modifying Units - Other	
25015 Note T10.3 Note T10.4.4	Anaesthesia, perfusion or assistance at anaesthesia - where the patient is less than 12 months of age or 70 years or greater	$17.15
	Subgroup 24 - Anaesthesia After Hours Emergency Modifier	

25030 Note T10.3	Assistance at after hours emergency anaesthesia where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies	Derived fee

Subgroup 4 - Gynaecological

35633	Hysteroscopy with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of iud which cannot be removed by other means, 1 or more of (Anaes.)	$172.45
35657 Note T8.33	Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)(Assist.)	$533.65
35687 Note T8.33	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)(Assist.)	$257.25
35688 Note T8.33	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)(Assist.)	$314.25
35691 Note T8.33	Sterilisation by interruption of fallopian tubes, when performed in conjunction with Caesarean section note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)	$125.55

Subgroup 5 - Urological

37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for ivf (Anaes.)	$218.75
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for ivf (Anaes.)(Assist.)	$546.95

37619	Vasovasostomy or vasoepididymostomy, unilateral, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for ivf (Anaes.)(Assist.)	$218.75
37622 Note T8.33	Vasotomy or vasectomy, unilateral or bilateral note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)	$152.90
37623 Note T8.33	Vasotomy or vasectomy, unilateral or bilateral note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note t8.33 before submitting a claim. (Anaes.)	$181.85
	Subgroup 6 - Cardio-Thoracic	
38215 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$350.90
38218 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$526.30
38220 Note T8.33 Note T8.35	Selective coronary graft angiography placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$175.45
38222 Note T8.33 Note T8.35	Selective coronary graft angiography, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$350.90
38225 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$526.35

38228 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$701.80
38231 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.)	$877.25
38234 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.)	$701.75
38237 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.)	$877.20
38240 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.)	$1,052.65
38243 Note T8.33 Note T8.35	Placement of catheter(s) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.)	$350.90

38246 Note T8.33 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 3823, 38240 or 38243 applies (Anaes.)	$877.20
38281	Permanent cardiac pacemaker, insertion, removal or replacement of (Anaes.)	$202.05
38742	Atrial septal defect, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.)(Assist.)	$1,521.95

DIAGNOSTIC IMAGING SERVICES

GROUP I1 - ULTRASOUND

Subgroup 2 - Cardiac

55113 Note DIH1.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of item 55054) or 3, or another item in this subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (r)	$242.80
55114 Note DIH1.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of item 55054) or 3, or another item in this subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (r)	$242.80
55115 Note DIH1.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of item 55054) or 3, or another item in this subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (r)	$242.80

55116 Note DIH1.1	Exercise stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r)	$270.00
55117 Note DIH1.1	Pharmacological stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in subgroups 1 (with the exception of item 55054) or 3, or another item in this subgroup, applies (with the exception of items 55118 and 55130). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r)	$270.00
55118 Note DIH1.1	Heart, 2 dimensional real time transoesophageal examination of, from at least two levels, and in more than one plane at each level, with: (a) pulsed wave Doppler examination; (b) real time colour flow mapping; and (c) recordings on video tape or digital medium; and not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (r) (Anaes.)	$290.00
	Subgroup 3 - Vascular	
55238 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25
55244 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25
55246 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25

55248 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25
55252 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25
55274 Note DIH5 Note DIH5.3	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R)	$155.25
55276 Note DIH5 Note DIH5.3 Note DIH5.4	duplex scanning involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (r)	$155.25
55278 Note DIH5 Note DIH5.3 Note DIH5.4	Duplex scanning involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (r)	$155.25
55280 Note DIH5 Note DIH5.3	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25

55282 Note DIH5 Note DIH5.3	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vasular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$155.25
55284 Note DIH5 Note DIH5.3	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R)	$155.25
55292 Note DIH5 Note DIH5.3	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a serivce associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (r)	$155.25
55294 Note DIH5 Note DIH5.3	Duplex scanning, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins or arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (r)	$155.25

PATHOLOGY SERVICES

GROUP P2 - CHEMICAL

66500 Changes	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acetoacetate, acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, beta-hydroxybutyrate, bicarbonate, bilirubin (total), bilirubin (any fractions), c-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, pyruvate, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test	$9.45
66626 Changes	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program; but excluding the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid - each episode, to a maximum of 36 episodes in a 12 month period	$23.80
66655 Changes	Prostate specific antigen - quantitation - 1 patient episode in a 12 month period	$19.90
	GROUP P3 - MICROBIOLOGY	
69345 Changes	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins or antigens not elsewhere specified in this Table; and (c) a service described in item 69300; with no more than 3 examinations performed on separately identified specimens, collected at different times in any 7 day period - 1 examination	$51.65
	GROUP P8 - INFERTILITY AND PREGNANCY TESTS	
73527 Changes	Human chorionic gonadotrophin (hcg) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy 1 or more tests	$9.90

Derived Fee Descriptions Commencing 1 May 2002 **(These 4 Item numbers were the only Items affected by the 1 May 2002 Medicare Benefits Schedule changes, and only Item 25030 had a change to it's derived fee. All other derived fee remain as they appear in the 1 November 2001 derived fees segment.**

Item 2673 An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient.

Item 2675 An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient.

Item 2677 An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient.

Item 25030 An additional amount of 50% of the fee for assistance at anaesthesia. That is:
(a) an assistant anaesthesia item in the range 25200 - 25205 plus,
(b) an item in the range 23010 - 24136, plus
(c) where applicable, an item in the range 25000 - 25015 plus,
(d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 25050

Medicare Benefits			
Item No.	**Schedule Fee $**	**75%**	**85% max Gap**
820	110.00	82.50	93.50
822	165.00	123.75	140.25
823	220.00	165.00	187.00
825	79.00	59.25	67.15
826	126.00	94.50	107.10
828	173.00	129.75	147.05
830	110.00	82.50	93.50
832	165.00	123.75	140.25
834	220.00	165.00	187.00
835	79.00	59.25	67.15
837	126.00	94.50	107.10
838	173.00	129.75	147.05
2517	28.75	21.60	24.45
2546	28.75	21.60	24.45
2552	54.60	40.95	46.45
2558	80.40	60.30	68.35
2620	21.00	15.75	17.85
2664	21.00	15.75	17.85
2666	38.00	28.50	32.30
2668	61.00	45.75	51.85
11601	54.80	41.10	46.60
13020	204.70	153.55	174.00
16518	274.15	205.65	233.05
20192	171.50	128.65	145.80
20300	85.75	64.35	72.90
20403	85.75	64.35	72.90
20420	85.75	64.35	72.90
20520	102.90	77.20	87.50
20940	51.45	38.60	43.75
20943	68.60	51.45	58.35
20956	68.60	51.45	58.35
20958	85.75	64.35	72.90
20960	120.05	90.05	102.05
21170	137.20	102.90	116.65
21402	120.05	90.05	102.05
21884	257.25	192.95	218.70
21941	120.05	90.05	102.05
21942	171.50	128.65	145.80
22012	51.45	38.60	43.75
22060	343.00	257.25	291.55
25015	17.15	12.90	14.60
35633	172.45	129.35	146.60
35657	533.65	400.25	478.05
35687	257.25	192.95	218.70
35688	314.25	235.70	267.15
35691	125.55	94.20	106.75
37604	218.75	164.10	185.95
37616	546.95	410.25	491.35
37619	218.75	164.10	185.95
37622	152.90	114.70	130.00
37623	181.85	136.40	154.60
38215	350.90	263.20	298.30
38218	526.30	394.75	470.70
38220	175.45	131.60	149.15
38222	350.90	263.20	298.30
38225	526.35	394.80	470.75
38228	701.80	526.35	646.20
38231	877.25	657.95	821.65
38234	701.75	526.35	646.15
38237	877.20	657.90	821.60
38240	1052.65	789.50	997.05
38243	350.90	263.20	298.30
38246	877.20	657.90	821.60
38281	202.05	151.55	171.75
38742	1521.95	1141.50	1466.35
55113	242.80	182.10	206.40
55114	242.80	182.10	206.40
55115	242.80	182.10	206.40
55116	270.00	202.50	229.50
55117	270.00	202.50	229.50
55118	290.00	217.50	246.50
55238	155.25	116.45	132.00
55244	155.25	116.45	132.00
55246	155.25	116.45	132.00
55248	155.25	116.45	132.00
55252	155.25	116.45	132.00
55274	155.25	116.45	132.00
55276	155.25	116.45	132.00
55278	155.25	116.45	132.00
55280	155.25	116.45	132.00
55282	155.25	116.45	132.00
55284	155.25	116.45	132.00
55292	155.25	116.45	132.00
55294	155.25	116.45	132.00
66500	9.45	7.10	8.05
66626	23.80	17.85	20.25
66655	19.90	14.95	16.95
69345	51.65	38.75	43.95
73527	9.90	7.45	8.45