Australian Government

Department of Health and Ageing

Supplement to Medicare Benefits Schedule of

1 November 2004

Effective 1 May 2005

Including new Strengthening Medicare items effective 1 January 2005

The Australian Government
Department of Health and Ageing

Strengthening Medicare

effective 1 January 2005

Explanatory Notes and Items

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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 2004 MEDICARE BENEFITS SCHEDULE

STRENGTHENING MEDICARE INITIATIVES EFFECTIVE 1 JANUARY 2005

Introduction

The Australian Government introduced a number of new initiatives as part of *Strengthening Medicare* on 1 January 2005. These initiatives are:

- 100% Medicare rebate for GP services.
- Round-the-Clock Medicare: higher Medicare rebates for after-hours GP services.
- New Medicare item for Pap smears provided by practice nurses on behalf of medical practitioners in regional, rural and remote areas - Item 10998.
- Access to the higher ($7.65) bulk billing incentive for medical practitioners providing after-hours services in eligible areas - Item 10992.

100% Medicare rebate for GP services

On 1 January 2005, the Medicare benefit (or rebate) for most services provided by a general practitioner increased from 85% to 100% of the Schedule Fee. The 100% Medicare rebate applies to services provided by both vocationally and non-vocationally registered GPs.

The 100% Medicare rebate applies to non-referred attendances (ie consultations) provided by a GP, except where the patient has been admitted to a hospital. The 100% Medicare rebate also applies to services provided by a practice nurse on behalf of a GP.

The Medicare items that attract a 100% Medicare rebate are listed below on page 11.

Round-the-Clock Medicare: higher Medicare rebates for after-hours GP services

On 1 January 2005, new Medicare items were introduced for after-hours GP consultations. The Medicare benefit for these items is $10 higher than the corresponding items used during non-after-hours periods.

There are 16 new after-hours items (item numbers 5000 to 5067) for vocationally registered GPs and 16 new after-hours items (item numbers 5200 to 5267) for other medical practitioners (non-vocationally registered GPs).

The Medicare benefit for the emergency after-hours items (1, 2, 97, 98, 601, 602, 697 and 698) has also increased by $10.

The new after-hours attendance items, and the emergency after-hours items, attract a 100% Medicare rebate. The item descriptions are listed below and begin on page 14.

The introduction of the after-hours attendance items has also affected some of the explanatory notes in the Medicare Benefits Schedule. Amended notes A.5, A.6, A.8 and A.10 are reproduced below on page 6.

Item 10998 - New Medicare item for Pap smears

A new MBS item for Pap smears that are taken by a practice nurse on behalf of a medical practitioner in a regional, rural or remote area also took effect on 1 January 2005.

Item 10998 attracts a 100% Medicare rebate. The explanatory notes for this item can be found on page 9 and the item description on page 22.

From 1 May 2005, a new item 10999 (similar to 10998) will apply to Pap smears taken from unscreened or significantly underscreened women by a practice nurse in a regional, rural or remote area. Item 10999 provides access to the Practice Incentives Program (PIP) cervical screening incentive for taking Pap smears from women who have not been screened for four years (see explanatory note M.2 on page 9).

Item 10992 - access to the higher ($7.65) bulk billing incentive for medical practitioners providing after-hours services in eligible areas

A new $7.65 bulk billing incentive item (10992) took effect on 1 January 2005. Item 10992 is for medical practitioners providing out-of-surgery after-hours services (eg Medical Deputising Services and members of GP after-hours services cooperatives) to claim a $7.65 incentive where the service is provided in an eligible area, even though the practitioner is not based in an eligible area.

Like the other bulk billing incentives, item 10992 does not attract a 100% Medicare rebate. The explanatory notes for this item can be found on page 8 and the item description on page 21.

A.5 Attendances by General Practitioners (Items 1-51, 193, 195, 197, 199, 601, 602, 2501-2559, 5000-5067)

A.5.1 Items 1 to 51 and 193, 195, 197, 199, 601, 602, 2501-2559, 5000-5067 relate specifically to attendances rendered by medical practitioners who are either:

- listed on the Vocational Register of General Practitioners maintained by the Health Insurance Commission;
- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) and who
- participate in, and meet the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or recognised by the RACGP as being at an equivalent standard.

Only general practitioners are eligible to itemise these content-based items. (See paragraphs 4.1, 4.2 and 4.3 of the General Explanatory Notes in the 1 November 2004 MBS Book for details of eligibility and registration.)

A.5.2 Items 1 to 51 and 5000 to 5067 cover four categories of general practitioner attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.5.3 The attendances are divided into four categories relating to the level of complexity.

A.5.4 To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes and examples in respect of the various levels are given. The fact that a particular case is used as an example does not mean that such cases would always be claimed at the level used in the example. Other modifying circumstances might prevail and each case must be treated on its merits.

LEVEL A

These items are for the obvious and straightforward cases and the practitioner's records would reflect this. In this context 'limited examination' means examination of the affected part if required, and 'management' the action taken.
Example: Triple Antigen or Tetanus Immunisation

LEVEL B

The descriptions of these items introduce the words 'selective history' and 'implementation of a management plan in relation to one or more problems'. In this context a 'selective history' means a history relating to a specific problem or condition; and 'implementation of a management plan' includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels A and B relate not to time but to complexity.
Example: Otitis media presenting as earache

LEVEL C

Further levels of complexity are implied in these items by the introduction of 'taking a detailed history' and 'examination of multiple systems'. A physical attendance of at least 20 minutes is necessary to qualify for a Level C attendance. The words following 'OR' in the items for Levels B and C allow for the situation where an attendance involves some components of a more complex level but the time taken is less than specified in the higher level. Benefit is claimable at the appropriate lower level, eg if an attendance involved a detailed history and examination of multiple systems, arranging investigations and implementing a management plan, but the time taken was less than 20 minutes, it would constitute a Level B attendance.
Example: Essential hypertension presenting as headache

LEVEL D

These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and

the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.

Examples: Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Counselling or Advice to Patients or Relatives

A.5.5 For items 23 to 51 and 5020 to 5067 'implementation of a management plan' includes counselling services.

A.5.6 Items 1 to 51 and 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes

A.5.7 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance

A.5.8 Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes in the 1 November 2004 MBS Book for further details).

After-Hours Attendances (Items 5000 - 5067 and 5200 - 5267)

A.5.9 There are attendance items (5000 - 5067 and 5200 - 5267) for medical services that are rendered after-hours. These items apply to GP and other non-referred attendances provided after-hours in a consulting room, residential aged care facility, institution or home.

A.5.10 An after-hours attendance or visit is a reference to a consultation provided on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a weekday not being a public holiday. In order to claim items 5000 - 5067 and 5200 - 5267, the professional attendance itself must begin in an after-hours period regardless of when the appointment was made.

A.5.11 Where a practice or clinic routinely conducts its business during an after-hours period as quoted above, the medical practitioner would only use the after-hours attendance items (items 5000 - 5067 and 5200 - 5267) and not the emergency after-hours items (1, 2, 97, 98, 448, 449, 601, 602, 697, 698).

Locum-Tenens

A.5.12 Where a general practitioner engages, either as an assistant or as a locum tenens, a medical practitioner who is not a general practitioner, Medicare benefits in respect of attendances rendered by the latter are attracted under items 52 - 96 and 5200 - 5267 and not under items 1 - 51 and 5000 - 5067.

A.6 Professional Attendances at an Institution (Items 13, 25, 38, 48, 81, 83, 84, 86, 5007, 5026, 5046, 5064, 5240, 5243, 5247, 5248)

A.6.1 For the purposes of these items an "institution" means a place (not being a hospital or residential aged care facility) at which residential accommodation or day care or both such accommodation and such care is made available to:-

(a) disadvantaged children;
(b) juvenile offenders;
(c) aged persons;
(d) chronically ill psychiatric patients;
(e) homeless persons;
(f) unemployed persons;
(g) persons suffering from alcoholism;
(h) persons addicted to drugs; or
(i) physically or intellectually disabled persons.

Note: See also paragraph A.9 in the 1 November 2004 MBS Book.

A.8 Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)

A.8.1 These items refer to attendances on patients in residential aged care facilities.

A.8.2 Where a medical practitioner attends a patient in a self-contained unit, within a residential aged care facility complex, the attendance attracts benefits under the appropriate home visit item.
A.8.3 Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the residential aged care facility, or at free standing consulting rooms within the residential aged care facility complex, the appropriate surgery consultation item applies.
A.8.4 If a patient who is accommodated in the residential aged care facility visits a medical practitioner at consulting rooms situated within the residential aged care facility complex, whether free standing or situated within the residential aged care facility precincts, benefits would be attracted under the appropriate residential aged care facility attendance item.
Note: See also paragraph A.9 in the 1 November 2004 MBS Book.

A.10 Emergency After-Hours Attendances (Items 1, 2, 97, 98, 448, 449, 601, 602, 697, 698)

A.10.1 In addition to the after-hours attendance items, there are emergency after-hours items (1, 2, 97, 98, 448, 449, 601, 602, 697, 698). These emergency after-hours items should only be used in the following instances:

- the consultation is initiated by or on behalf of the patient in the same unbroken after-hours period (on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a weekday not being a public holiday);
- the patient's medical condition must require immediate treatment; and
- if more than one patient is seen on the one occasion, items 1, 2, 97, 98,448, 449, 601, 602, 697, 698 can be used but only in respect of the first patient. The normal after-hours attendance items for that particular location should be used in respect of the second and subsequent patients attended on the same occasion.

Where the patient is seen at a public hospital the following additional provisions would apply in relation to items 1, 97, 601 and 697:

- the first or only patient is a private in-patient; or
- the first or only patient is seen in the Out-patient or Casualty Department and the hospital does not provide at the time a medical Out-patient or Casualty service.

Where any of the above conditions do not apply the after-hours attendance items or the normal attendance items should be used.

A.10.2 Items 2, 98, 448, 449, 602 and 698 are intended to allow benefit for returning to and specially opening up consulting rooms to attend a patient who needs immediate treatment after-hours. As the extra benefit is for the inconvenience of actually returning to and opening the surgery it is payable only once on any one occasion - to the first patient seen after opening up. If other patients are seen on the same occasion, they are itemised as ordinary after-hours surgery attendance (items 5000 - 5067 and 5200 - 5267). In this respect, items 2, 98, 602 and 698 are the same as items 1, 97, 601 and 697.

A.10.3 Items 449, 601, 602, 697 698 are intended to allow benefit for emergency attendances in the 'unsociable hours', that is, 11pm - 7am on any day of the week. Apart from the time restriction, the conditions applying to items 601 and 697 are the same as those applying to items 1 and 97, and the conditions applying to items 449, 602 and 698 are the same as those applying to items 2, 98 and 448.

After-hours services provided in areas eligible for the higher bulk billing payment (item 10992)

M1.11 Item 10992 can only be claimed where all of the conditions set out in paragraphs (a) to (g) of item 10992 have been met:

- Item 10992 must be claimed in conjunction with one of the items listed in item 10992.These items are for services provided after-hours outside of consulting rooms or hospital.
- Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (ie the location associated with the medical practitioner's provider number) is not in one of these areas.
- Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

M1.12 Item 10992 cannot be claimed in conjunction with item 10990 or 10991.
M1.13 Where a Medicare benefit is not payable for a particular service the payment for item 10992 will not be paid for that service.
M1.14 All GPs, whether vocationally registered or not, are eligible to claim the additional bulk billing payment.
M1.15 Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

M1.16 Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.
M1.17 HIC will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

Pap smear services provided by a practice nurse (item 10998 and 10999)
M.2.20 Item 10998 can only be claimed by a medical practitioner where a Pap smear is taken by a practice nurse on behalf of the medical practitioner at a practice location in a regional, rural or remote area.
M.2.21 Item 10999 can only be claimed by a medical practitioner where a Pap smear is taken by a practice nurse on behalf of the medical practitioner at a practice location in a regional, rural or remote area **and** the Pap smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.
M.2.22 Where the medical practitioner claims item 10999 instead of a Practice Incentives Program (PIP) item (2497 - 2509 and 2598 - 2616) for an unscreened or significantly underscreened woman, a PIP cervical screening incentive will still be available. This incentive will be paid to the medical practitioner claiming item 10999 if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices that reach target levels of cervical screening for their female patients aged 20-69. More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip
M.2.23 Item 10999 cannot be claimed in conjunction with items 10998, 2497 - 2509 and 2598 - 2616.
M.2.24 A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.
M.2.25 A practice location is the place associated with the medical practitioner's provider number from which the service has been provided. If you are unsure if your practice location is in an eligible area you can call the HIC on 132 150.
M.2.26 A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.
M.2.27 The practice nurse must be appropriately qualified and trained to take cervical smears. This means that where credentialling arrangements are in place, the practice nurse should be credentialled as qualified and trained to take Pap smears. All practice nurses taking Pap smears should have undertaken an accredited training course.
M.2.28 Continuing professional development is a compulsory part of the credentialling arrangements and is recommended for all nurses taking Pap smears in jurisdictions where there are currently no credentialling arrangements.
M.2.29 General practices, where nurses take Pap smears, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.
M.2.30 The practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories.
M.2.31 In all cases, the medical practitioner under whose supervision the Pap smear is taken retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to take Pap smears.
M.2.32 The medical practitioner is not required to see the patient first or to be present while the Pap smear is taken. It is up to the medical practitioner to decide whether they need to initially see the patient. Where a consultation has taken place with the patient first then the medical practitioner is entitled to claim for that professional service.
M.2.33 All GPs whether vocationally registered or not are eligible to claim this item.
M.2.34 Item 10991 can also be claimed in conjunction with item 10998 and 10999 provided the conditions of item 10991 are satisfied (see explanatory note M.1 in the 1 November 2004 MBS Book).

SUMMARY OF CHANGES

The 1 January 2005 Strengthening Medicare items are summarised below and are identified in the Schedule pages by the symbol appearing above the item number:-

† New item
+ Fee amended
□ Benefit paid at100% of Schedule fee

New Items effective 1 January 2005

5000	5003	5007	5010	5020	5023	5026	5028	5040	5043	5046
5049	5060	5063	5064	5067	5200	5203	5207	5208	5220	5223
5227	5228	5240	5243	5247	5248	5260	5263	5265	5267	10992
10998										

Fee Amended effective 1 January 2005

1	2	97	98	601	602	697	698

Benefit Paid at 100% of Schedule fee effective 1 January 2005

1	2	3	4	13	20	23	24	25	35	36
37	38	43	44	47	48	51	52	53	54	57
58	59	60	65	81	83	84	86	92	93	95
96	97	98	160	161	162	163	164	170	171	172
173	193	195	197	199	601	602	697	698	700	702
704	706	710	712	720	724	726	728	730	734	736
738	740	742	744	759	762	765	775	778	779	900
903	2501	2503	2504	2506	2507	2509	2517	2518	2521	2522
2525	2526	2546	2547	2552	2553	2558	2559	2574	2575	2577
2578	2600	2603	2606	2610	2613	2616	2620	2622	2624	2631
2633	2635	2664	2666	2668	2673	2675	2677	2704	2705	2707
2708	2721	2723	2725	2727	5000	5003	5007	5010	5020	5023
5026	5028	5040	5043	5046	5049	5060	5063	5064	5067	5200
5203	5207	5208	5220	5223	5227	5228	5240	5243	5247	5248
5260	5263	5265	5267	10993	10996	10998				

Services that attract the 100% Medicare rebate from 1 January 2005

Medicare Benefits Schedule (MBS) Group	Name of Group	Item numbers
Group A1 *(all items other than items 19, 33, 40, 50)*	General practitioner attendances to which no other item applies	1, 2, 601, 602, 3, 4, 13, 20, 23, 24, 25, 35, 36, 37, 38, 43, 44, 47, 48, 51
Group A2 *(all items other than items 87, 89, 90, 91)*	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65, 81, 83, 84, 86, 92, 93, 95, 96, 97, 98, 697, 698
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A14	Health assessments	700, 702, 704, 706, 710, 712
Group A15 *(all items other than items 722, 746, 749, 757, 768, 771, 773, 820-866)*	Multidisciplinary care plans and multidisciplinary case conferences	720, 724, 726, 728, 730, 734, 736, 738, 740, 742, 744, 759, 762, 765, 775, 778, 779
Group A17	Medication management review	900, 903
Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559, 2574, 2575, 2577, 2578
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677, 2704, 2705, 2707, 2708
Group A20	Focussed psychological strategies	2721, 2723, 2725, 2727
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5007, 5010, 5020, 5023, 5026, 5028, 5040, 5043, 5046, 5049, 5060, 5063, 5064, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265, 5267
Group M2	Services provided by a practice nurse on behalf of a medical practitioner	10993, 10996, 10998

FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, HOSPITAL, INSTITUTION OR HOME

	LEVEL A FEE/ BENEFITS	BENEFITS		LEVEL B FEE/ BENEFITS	BENEFITS	
PATIENTS	**100%**	**85%**	**75%**	**100%**	**85%**	**75%**
ONE	$35.65	$30.35	$26.75	$52.40	$44.55	$39.30
TWO	$24.85	$21.15	$18.65	$41.60	$35.40	$31.20
THREE	$21.30	$18.15	$16.00	$38.05	$32.35	$28.55
FOUR	$19.50	$16.60	$14.65	$36.25	$30.85	$27.20
FIVE	$18.40	$15.65	$13.80	$35.15	$29.90	$26.40
SIX	$17.70	$15.05	$13.30	$34.45	$29.30	$25.85
SEVEN+	$15.65	$13.35	$11.75	$32.40	$27.55	$24.30

	LEVEL C FEE/ BENEFITS	BENEFITS		LEVEL D FEE/ BENEFITS	BENEFITS	
PATIENTS	**100%**	**85%**	**75%**	**100%**	**85%**	**75%**
ONE	$80.10	$68.10	$60.10	$107.75	$91.60	$80.85
TWO	$69.30	$58.95	$52.00	$96.95	$82.45	$72.75
THREE	$65.75	$55.90	$49.35	$93.40	$79.40	$70.05
FOUR	$63.95	$54.40	$48.00	$91.60	$77.90	$68.70
FIVE	$62.85	$53.45	$47.15	$90.50	$76.95	$67.90
SIX	$62.15	$52.85	$46.65	$89.80	$76.35	$67.35
SEVEN+	$60.10	$51.10	$45.10	$87.75	$74.60	$65.85

FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, HOSPITAL, INSTITUTION OR HOME

	BRIEF FEE/ BENEFITS	BENEFITS		STANDARD FEE/ BENEFITS	BENEFITS	
PATIENTS	**100%**	**85%**	**75%**	**100%**	**85%**	**75%**
ONE	$24.00	$20.40	$18.00	$33.50	$28.50	$25.15
TWO	$16.25	$13.85	$12.20	$24.75	$21.05	$18.60
THREE	$13.65	$11.65	$10.25	$21.85	$18.60	$16.40
FOUR	$12.35	$10.50	$ 9.30	$20.35	$17.30	$15.30
FIVE	$11.60	$ 9.90	$ 8.70	$19.50	$16.60	$14.65
SIX	$11.10	$ 9.45	$ 8.35	$18.90	$16.10	$14.20
SEVEN+	$ 9.20	$ 7.85	$ 6.90	$16.70	$14.20	$12.55

	LONG FEE/ BENEFITS	BENEFITS		PROLONGED FEE/ BENEFITS	BENEFITS	
PATIENTS	**100%**	**85%**	**75%**	**100%**	**85%**	**75%**
ONE	$51.00	$43.35	$38.25	$73.00	$62.05	$54.75
TWO	$43.25	$36.80	$32.45	$65.25	$55.50	$48.95
THREE	$40.65	$34.60	$30.50	$62.65	$53.30	$47.00
FOUR	$39.35	$33.45	$29.55	$61.35	$52.15	$46.05
FIVE	$38.60	$32.85	$28.95	$60.60	$51.55	$45.45
SIX	$38.10	$32.40	$28.60	$60.10	$51.10	$45.10
SEVEN+	$36.20	$30.80	$27.15	$58.20	$49.50	$43.65

AFTER HOURS GP ATTENDANCES

FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, INSTITUTION OR HOME

	LEVEL A		LEVEL B	
	FEE	BENEFITS	FEE	BENEFITS
PATIENTS		**100%**		**100%**
ONE	$45.65	$45.65	$62.40	$62.40
TWO	$34.85	$34.85	$51.60	$51.60
THREE	$31.30	$31.30	$48.05	$48.05
FOUR	$29.50	$29.50	$46.25	$46.25
FIVE	$28.40	$28.40	$45.15	$45.15
SIX	$27.70	$27.70	$44.45	$44.45
SEVEN+	$25.65	$25.65	$42.40	$42.40

	LEVEL C		LEVEL D	
	FEE	BENEFITS	FEE	BENEFITS
PATIENTS		**100%**		**100%**
ONE	$90.10	$90.10	$117.75	$117.75
TWO	$79.30	$79.30	$106.95	$106.95
THREE	$75.75	$75.75	$103.40	$103.40
FOUR	$73.95	$73.95	$101.60	$101.60
FIVE	$72.85	$72.85	$100.50	$100.50
SIX	$72.15	$72.15	$99.80	$99.80
SEVEN+	$70.10	$70.10	$97.75	$97.75

AFTER HOURS OTHER NON REFERRED ATTENDANCES

FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, INSTITUTION OR HOME

	BRIEF		STANDARD	
	FEE	BENEFITS	FEE	BENEFITS
PATIENTS		**100%**		**100%**
ONE	$34.00	$34.00	$43.50	$43.50
TWO	$26.25	$26.25	$34.75	$34.75
THREE	$23.65	$23.65	$31.85	$31.85
FOUR	$22.35	$22.35	$30.35	$30.35
FIVE	$21.60	$21.60	$29.50	$29.50
SIX	$21.10	$21.10	$28.90	$28.90
SEVEN+	$19.20	$19.20	$26.70	$26.70

	LONG		PROLONGED	
	FEE	BENEFITS	FEE	BENEFITS
PATIENTS		**100%**		**100%**
ONE	$61.00	$61.00	$83.00	$83.00
TWO	$53.25	$53.25	$75.25	$75.25
THREE	$50.65	$50.65	$72.65	$72.65
FOUR	$49.35	$49.35	$71.35	$71.35
FIVE	$48.60	$48.60	$70.60	$70.60
SIX	$48.10	$48.10	$70.10	$70.10
SEVEN+	$46.20	$46.20	$68.20	$68.20

	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	EMERGENCY ATTENDANCES - AFTER HOURS
□ + 1	**EMERGENCY ATTENDANCE AFTER HOURS** **(on not more than 1 patient on 1 occasion)** Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $108.05 **Benefit:** 100% = $108.05
□ + 2	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $108.05 **Benefit:** 100% = $108.05
□ + 601	Professional attendance, at a place **OTHER THAN CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am*** *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $127.25 **Benefit:** 100% = $127.25
□ + 602	Professional attendance, **AT CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am*** *(See para A.5 and A.10 of explanatory notes to this Category)* **Fee:** $127.25 **Benefit:** 100% = $127.25

	EMERGENCY ATTENDANCE - AFTER HOURS
□ + 97	**(on not more than 1 patient on 1 occasion)** Professional attendance after hours **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 of explanatory notes to this Category)* **Fee:** $94.05 **Benefit:** 100% = $94.05
□ + 98	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am*****,** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 of explanatory notes to this Category)* **Fee:** $94.05 **Benefit:** 100% = $94.05
□ + 697	Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am*** *(See para A.10 of explanatory notes to this Category)* **Fee:** $111.50 **Benefit:** 100% = $111.50
□ + 698	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am*** *(See para A.10 of explanatory notes to this Category)* **Fee:** $111.50 **Benefit:** 100% = $111.50

	GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
† □ 5000	**LEVEL 'A'** Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $24.10 **Benefit:** 100% = $24.10
† □ 5003	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $1.55 per patient
† □ 5007	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $1.55 per patient
† □ 5010	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $1.55 per patient
† □ 5020	**LEVEL 'B'** Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $40.85 **Benefit:** 100% = $40.85
† □ 5023	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $1.55 per patient
† □ 5026	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $1.55 per patient

† □ 5028	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $1.55 per patient
† □ 5040	**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 1 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 **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $68.55 **Benefit:** 100% = $68.55
† □ 5043	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution). The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.55 per patient
† □ 5046	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.55 per patient
† □ 5049	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.55 per patient
† □ 5060	**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 1 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 **SURGERY CONSULTATION** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Fee:** $96.20 **Benefit:** 100% = $96.20
† □ 5063	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.55 per patient

† □ 5064	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.55 per patient
† □ 5067	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.55 per patient

	GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	(Professional attendance at consulting rooms)
† □ 5200	**BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) **Fee:** $21.00 **Benefit:** 100% = $21.00
† □ 5203	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $31.00 **Benefit:** 100% = $31.00
† □ 5207	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $48.00 **Benefit:** 100% = $48.00
† □ 5208	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $71.00 **Benefit:** 100% = $71.00
	HOME VISITS (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)
† □ 5220	**BRIEF HOME VISIT** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $18.50, 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 $18.50 plus $.70 per patient
† □ 5223	**STANDARD HOME VISIT** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $26.00, 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 $26.00 plus $.70 per patient
† □ 5227	**LONG HOME VISIT** of more than 25 minutes duration but not more than 45 minutes duration The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $45.50, 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 $45.50 plus $.70 per patient
† □ 5228	**PROLONGED HOME VISIT** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Derived Fee:** An amount equal to $67.50, 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 $67.50 plus $.70 per patient
	CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient
† □ 5240	**BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, 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 $18.50 plus $.70 per patient
† □ 5243	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, 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 $26.00 plus $.70 per patient

† □ 5247	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, 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 $45.50 plus $.70 per patient
† □ 5248	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, 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 $67.50 plus $.70 per patient
† □ 5260	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) - each patient **BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, 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 $18.50 plus $.70 per patient
† □ 5263	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, 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 $26.00 plus $.70 per patient
† □ 5265	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, 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 $45.50 plus $.70 per patient
† □ 5267	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, 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 $67.50 plus $.70 per patient

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES

A medical service to which item 1, 97, 601, 697, 5003, 5007, 5010, 5023, 5026, 5028, 5043, 5046, 5049, 5063, 5064, 5067, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265 or 5267 applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital or approved day-hospital facility; and

(d) the service is not provided in consulting rooms; and

(e) the service is provided in one of the following eligible areas:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and

(g) the service is bulk billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service.

† *(See para M1 of explanatory notes to this Category)*

10992 **Fee:** $9.00 **Benefit:** 85% = $7.65

MISCELLANEOUS	
	GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER
† □ 10998	Service provided by a practice nurse, being the taking of a cervical smear from a person, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the person is not an admitted patient of a hospital or approved day hospital facility. *(See para M2 of explanatory notes to this Category)* **Fee:** $10.20 **Benefit:** 100% = $10.20
Effective 1 May 2005 † □ 10999	Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the person is not an admitted patient of a hospital or approved day hospital facility. This item cannot be claimed with items 2497- 2509 and 2598-2616 *(See para M2 of explanatory notes to this Category)* **Fee:** $10.20 **Benefit:** 100% = $10.20

The Australian Government
Department of Health and Ageing

Supplement to the

Medicare Benefits Schedule

Of 1 November 2004

Effective 1 May 2005

SUPPLEMENT TO 1 NOVEMBER 2004 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2005

This supplement provides details of changes to the 1 November 2004 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2004 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.

MEDICARE SAFETY NET

The difference between the Medicare rebate and the schedule fee for out-of-hospital Medicare services counts towards the Medicare Benefits safety net threshold. Once the threshold of $335.50 is reached by a registered family or individual in a calendar year, patients are reimbursed 100% of the Schedule fee rather than the standard Medicare benefit of 85% for all other Medicare services for the remainder of the calendar year.

The Medicare safety net threshold increased with effect from 1 January 2005.

EXTENDED MEDICARE SAFETY NET

The extended Medicare safety net meets 80% of the out-of-pocket costs (ie the difference between the fees charged and the Medicare benefits paid) for out-of-hospital Medicare services, once an annual threshold of $306.90 for registered families in receipt of Family Tax Benefit (A) and concession card holders, or $716.10 for all other individuals and families is reached. These thresholds were increased with effect from 1 January 2005.

Individual and family safety net thresholds are calculated and monitored by the Health Insurance Commission. Individuals are automatically registered with Medicare for the safety net threshold and families are required to register with Medicare to be eligible.

Safety net thresholds include out-of-pocket expenses for all out-of-hospital Medicare services accrued from 1 January 2005. Once an individual or family has reached the relevant threshold claims will be paid at the higher rate for the remainder of the calendar year.

The existing Medicare Benefits safety net will continue to operate in conjunction with the extended Medicare safety net.

AMENDMENTS TO GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Consultant psychiatrist referred patient assessment and management plan** – Item 291 has been introduced to facilitate GP management of a patient, where the GP refers a patient to a consultant psychiatrist for the provision of an assessment and management plan, and a detailed written plan is provided back to the GP who provides ongoing care. In most cases it is expected that item 291 will be a single attendance. However, item 293 has been introduced to allow for those circumstances where the GP considers that the current plan is not achieving the anticipated outcomes, and requests from the consultant psychiatrist a review of the plan previously provided under item 291.
- **General Practitioner Attendances and Other Non-Referred Attendances Associated with Practice Incentives Program (PIP) Incentive Payments (Group A18 and A19)** Changes to the explanatory notes of A28.7, A.29.8, A30.5 and A.31.1 update the information provided about payments made through the Practice Incentives Program (PIP). Other changes to the use of items in Group A18 and A19 include:

    — **Taking of a Cervical Smear from an unscreened or significantly underscreened woman** Following the recommendations of the Red Tape Taskforce, items 2497 and 2598 have been introduced to extend the range of consultation items that can trigger a PIP incentive to shorter consultation. These new items attract a Medicare benefit equal to 100% of the Medicare schedule fee. Explanatory note A.28 has been amended following the introduction of items 2497, 2598, 10998 and 10999.

— **Annual cycle of care for patients with diabetes mellitus** - Following the recommendations of the Red Tape Taskforce, items 2517 and 2620 have been amended to allow practitioners to complete an annual cycle of care per patient in an 11 to 13 month period. This is reflected in amendments to the explanatory note of A29.5.

— **3 Step Mental Health Process**- Following the recommendations of the Better Outcomes Implementation Advisory Group, items 2574 and 2704 have been amended to allow practitioners to complete the 3 Step Mental Health process in two long consultations. This is reflected in amendments to the explanatory note A31.5.

- **Pap smears provided by a practice nurse on behalf of a medical practitioner -** On 1 January 2005,item 10998 was introduced to provide a Medicare rebate for Pap smears taken by practice nurses on behalf of medical practitioners in regional, rural and remote areas. From 1 May 2005, a new item (10999) will apply to Pap smears taken from unscreened or significantly under-screened women by a practice nurse on behalf of a medical practitioner in regional, rural and remote areas. Item 10999 provides access to the Practice Incentives Program (PIP) incentive payment applying to unscreened or significantly under-screened women. Item 10999 can not be claimed in conjunction with items 2497 - 2509 and 2598 - 2616.
  Where the practice is not eligible for PIP incentive payments or the woman is not in the target group covered by item 10999, item 10998 should be claimed. The explanatory notes for these items can be found on page 9 and the item description on page 22.
- **Capsule endoscopy** - Item 11820 has been amended to extend the patient group to patients aged 10 years and over.
- **Dermatology** - A minor amendment has been made to items 14106 and14124 to clarify the original intent of the items.
- **Procedures on the abdominal viscera** Item 30375 has been amended so that procedures can be performed either by laparotomy or laparoscopically.
- **Implanted drug delivery systems for** pain management - items 14218, 39125,39126, 39127,39128 and 39133 have been amended to clarify that they are for the implantation of infusion pumps and insertion of epidural or spinal catheters for the management of chronic intractable pain. The items are not to be used for insertion of catheters at surgical sites for post-operative pain management.
- **General Surgery** - Item 30403 (ventral, incisional or recurrent hernia or burst abdomen repair) has been amended to clarify that it covers repairs with or without the use of mesh. Item 30405 (ventral or incisional hernia repair) has been amended to state that it excludes repair of recurrent inguinal or femoral hernia.
- **General Surgery** - New items have been included and current items amended in the range31255-31295 to distinguish between the removal of primary tumours as opposed to those which are residual or recurrent. Note T8.22 has been amended to reflect the changes to these items.
- **Interventional radiology**-Items 30440 and 30451(for biliary drainage) have been amended to clarify the circumstances under which the items can be claimed. Items for biliary procedures (30492 and 30495), endovascular procedures (35331 and 35360-35363) and urological procedures (36605, 36607, 36608 and 36650) have been introduced to reflect current practice in interventional radiology.
- **Morbid obesity** Item 30514 has been amended to clarify that surgical reversal of gastric reduction, gastroplasty or bypass can be performed by any method. New note T8.19 has been added to explain which items can be claimed for revision surgery.
- **Gynaecology**

The pelvic floor surgery section has been revised.
Eight items have been deleted:

- 35567, 35576, 35580, 35584, 35587, 35590, 35593, 35600

Eight new items have been introduced:

- 35570 anterior vaginal compartment repair by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh
- 35571 posterior vaginal compartment repair by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh
- 35573 anterior and posterior vaginal compartment repair by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh
- 35595 for laparoscopic or abdominal pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse
- 35597 for sacral colpopexy, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse
- 35568 sacrospinous colpopexy for management of upper vaginal prolapse (formerly included in 35567)

- 35577 Manchester (Donald Fothergill) operation for genital prolapse, with or without mesh (formerly included in 35584)
- 35578 Le Fort Operation for genital prolapse (formerly included in 35584)
- Item 35617 G/35618 S has been amended to replace the reference to item 35584 with the new items replacing it (Items 35577 or 35578).

- **Ophthalmology** □ Note T8.65has been amended to include items 42722, 42725 and 42740 in the range of intraocular operations which should not be claimed with item 42731.
- **Plastic & Reconstructive surgery** □ Note T8.82 has been amended to clarify that items 45557 and 45558 are payable only once per patient.

Referred Patient Assessment and Management Plan (Items 291 to 293)

A.15.1 Referral for items 291 to 293 should be through the GP for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP.

A.15.2 In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and review stage of treatment, where clinically appropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)
- Health of the Nation Outcome Scales (HoNOS)

A.15.3 Preparation of the management plan should be in consultation with the patient. If appropriate, a written copy of the management plan should be provided to the patient. A written copy of the management plan should be provided to the general practitioner within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the GP may be appropriate. A guide to the content of the report which should be provided to the GP under this item is included within this Schedule.

A.15.4 It is expected that item 291 will be a single attendance. In some circumstances a consultation with the patient may be required before undertaking item 291. In these circumstances a claim would be made under items 300-308.

A.15.5 Item 293 is available in instances where the GP initiates a review of the plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs. An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org)

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

- The following content outline is indicative of what would usually be sent back to GPs.
- The Management plan should address the specific questions and issues raised by the GP.
- In most cases the patient is usually well known by the GP.

History and Examination

This should focus on the presenting symptoms and current difficulties, including precipitating and ongoing stresses; and only briefly mention any relevant aspects of the patient's family history, developmental history, personality features, past psychiatric history and past medical history.

It should contain a comprehensive relevant Mental Status Examination and any relevant pathology results if performed.

It should summarise any psychological tests that were performed as part of the assessment.

Diagnosis

A diagnosis should be made either using ICD 10 or DSM IV classification.

In some cases the diagnosis may differ from that stated by the GP, and an explanation of why the diagnosis differs should be included.

Psychiatric formulation
A brief integrated psychiatric formulation focussing on the biological, psychological and physical factors. Any precipitant and maintaining factors should be identified including relevant personality factors. Protective factors should also be noted. Issues of risk to the patient or others should be highlighted.

Management plan

1. ***Education***
   Include a list of any handout material available to help people understand the nature of the problem. This includes recommending the relevant RANZCP consumer and carer clinical practice guidelines.

2. ***Medication recommendations***
   Give recommendations for immediate management including the alternatives or options. This should include doses, expected response times, adverse effects and interactions, and a warning of any contra-indicated therapies.

3. ***Psychotherapy***
   Recommendations should be given on the most appropriate mode of psychotherapy required, such as supportive psychotherapy, cognitive and behavioural psychotherapy, family or relationship therapy or intensive explorative psychotherapy. This should include recommendations on who should provide this therapy.

4. ***Social measures***
   Identify issues which may have triggered or are contributing to the maintenance of the problem in the family, workplace or other social environment which need to be addressed, including suggestions for addressing them.

5. ***Other non medication measures***
   This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations, discussion of any complementary medicines, reading recommendations, relationship with other support services or agencies etc.

6. ***Indications for re-referral***
   It is anticipated that the majority of patients will be able to be managed effectively by the GP using the plan. If there are particular concerns about the possible need for further review, these should be noted.

7. ***Longer term management***
   Provide a longer term management plan listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as a relapse signature and relapse drill, and should include drug doses and other indicated interventions, expected response times, adverse effects and interactions.

A.28 Taking a cervical smear from a woman who is unscreened or significantly underscreened (Items 2497 - 2509 and 2598 - 2616)

A.28.1 The item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last four years. These items cannot be used in conjunction with item 10999.

A.28.2 The items apply only to women between the ages of 20 and 69 years inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

A.28.3 When providing this service, the doctor must satisfy themselves that the woman has not had a cervical smear in the last four years by:

- asking the woman if she can remember having a cervical screen in the last four years; and
- checking their own practice's medical records.

If significant uncertainty still remains, the doctor may also contact his/her state cervical screening register.

A.28.4 Women from the following groups are more likely than the general population to be unscreened or significantly underscreened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.
A.28.5 Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.
A.28.6 In addition to attracting a Medicare rebate, the use of these items will initiate a cervical screening incentive payment through the Practice Incentives Program (PIP).
A.28.7 A PIP cervical screening incentive is available for taking a cervical screen from women who have not been screened for four years. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices who reach target levels of cervical screening for their female patients aged 20-69 years inclusive. More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.29 Completion of an annual cycle of care for patients with diabetes mellitus (Items 2517 - 2526, 2620 - 2635)

A.29.1 The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum annual requirements of care for a patient with established diabetes mellitus.
A.29.2 The minimum requirements of care are:

Assess diabetes control by measuring HbA1c	At least once every 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
Measure blood pressure	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 every 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

* Initial visit: measure height and weight and calculate BMI as part of the initial assessment. Subsequent visits: measure weight.

A.29.3 These requirements are based on the general practice guidelines produced by the Royal Australian College of General Practitioners and Diabetes Australia (DA/RACGP, *Diabetes Management in General Practice,* 6th ed., 2000). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.
A.29.4 Use of these items certifies that the minimum annual cycle of care has been completed for a patient with established diabetes mellitus in accordance with the guidelines above.
A.29.5 These items should only be used once per year 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 year.
A.29.6 The requirements for claiming this item are the minimum needed to provide good care to a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.
A.29.7 In addition to attracting a Medicare rebate, recording an annual completion of care cycle through the use of these items will initiate a diabetes incentive payment through the Practice Incentives Program (PIP).
A.29.8 A PIP diabetes incentive is available for completion of an annual cycle care for individual patients. This incentive is only paid once per year per patient. This incentive will be paid to the medical practitioner who provided

the service if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices which reach target levels of care for their patients with diabetes . More detailed information on these incentives is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.30 Completion of the Asthma 3+ Visit Plan (Items 2546 - 2559, 2664 - 2677)

Minimum Requirements

A.30.1 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:

- Documented diagnosis and assessment of severity,
- At least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma,
- Review of the patient's use of asthma-related medication,
- Planned recalls for at least two of these consultations,
- 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.

It is expected that at some point in the future, the use of spirometry will become a requirement of the diagnosis and assessment of severity for the purposes of the Asthma 3+ Visit Plan. All doctors will be given adequate notice of this change prior to its introduction.

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, but 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.30.2 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.30.3 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.30.4 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 A30.1

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)

Engagement Visit

If your patient presents solely for an asthma-related problem, or it is clinically appropriate and possible, include the items in Visit 1. However, there will often be visits at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation. In either case:

- Manage the issue that caused asthma to be discussed, e.g. worsening asthma symptoms, request for a script (ensure that you record the asthma-related activities).
- Introduce the concept of a 'partnership' for care: the **Asthma 3+ Visit Plan** and the reasons for review, and gain the patient's agreement.
- Give the **Asthma 3+ Visit Plan handout** to the patient.

Visit 1

- **New patient: ascertain status, including history, medication and management**. (Asthma Management Handbook p58-59)
- **Existing patient: assess present situation, including review of medical records and consolidation/collection of information on history, medication and management.** (p58-59)
- What do they know and what do they need to know? (knowledge) (p60-61 & p65-66)
- Advise patient about their local Asthma Foundation's 3+ Community Support Program - telephone 1800 645 130
- How do they feel about their asthma? (perception)
- What do they want from you, the GP? (expectations)
- Review medication devices technique and adherence. (p33, p55-57 & p62-63)
- Perform physical examination (including spirometry). (p4-7 & p36)
- Grade asthma severity and level of control. (p14-15 & p28)
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting. (p6-7 & p36)
- Is a change in medication required? (p22 & p32)
- Agree on a date for the next visit.

Visit 2 (approximately 2 weeks later)

- Review patient and his/her PEFR record.
- Perform spirometry (if not already done, or consider redoing). (p4-5 & p36)
- Complete written Asthma Action Plan or review existing plan. (p23-25 & p33-35)
- Further identify trigger factors: consider RAST, skin-prick tests (if not already done). (p17-19 & p37)
- Is a change in medication required? (p22 & p32)
- Check on, reinforce and expand education. (p65-66)
- Answer any questions.
- Agree on a date for the next visit.

Visit 3 (approximately 4 weeks later) [This is where the relevant MBS asthma item should be claimed to trigger the PIP payment.]

- Assess progress.
- Review Asthma Action Plan.
- Review medication requirements according to asthma control.
- Discuss results of trigger factor tests (if applicable).
- Check on, reinforce and expand education.
- Answer any questions.

Subsequent visits (every 3 or 6 months as clinically appropriate) [These would be billed as usual consultation items.]

- Assess progress and asthma control, including spirometry.
- Review Asthma Action Plan and medication needs.
- Emphasise the benefits of adherence and assess medication device technique.
- Check on, reinforce and expand education.
- Answer any questions.

All references are from Asthma Management Handbook 2002. National Asthma Council, Melbourne, 2002.

All references are from Asthma Management Handbook 2002. National Asthma Council, Melbourne, 2002.

A.30.5 A PIP Asthma 3+ Visit Plan incentive is available for completing the minimum requirements of the Asthma 3+ Visit Plan as specified in clause A.30.1 above. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. More detailed information on this incentive is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.31 Completion of the 3 Step Mental Health Process (Items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) Minimum Requirements

A.31.1 A PIP Mental Health incentive is available for providing the minimum requirements of the 3 Step Mental Health Process as specified in clause A.30.5 below. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP. More detailed information on this incentive is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.31.2 The item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708 can be accessed by practitioners who have completed the mental health Familiarisation Training and have the appropriate mental health skills as required by the General Practice Mental Health Standards Collaboration. Continued access to item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708 will be dependent on the medical practitioner meeting ongoing education requirements as determined by the General Practice Mental Health Standards Collaboration.

A.31.3 The item numbers 2574, 2575, 2577, 2578 and 2704, 2705, 2707,2708 should be used in place of the usual attendance item when a consultation completes the requirements of the 3 Step Mental Health Process.

A.31.4 Mental Health Disorder

A Mental Health disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder - this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. These disorders include:

- Alcohol use disorders
- Chronic psychotic disorders
- Bipolar disorder
- Phobic disorders
- Generalised anxiety
- Adjustment disorder
- Unexplained somatic complaints
- Eating disorders
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Drug use disorders
- Acute psychotic disorders
- Depression
- Panic disorder
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis
- Mental disorder, not otherwise specified

but exclude dementia, delirium, tobacco use disorder and mental retardation.

A.31.5 3 Step Mental Health Process

At a minimum the 3 Step Mental Health Process must include:

- at least 2 consultations of more than 20 minutes each for a patient with an assessed mental health disorder;
- at least two of the consultations to have been planned visits;
- assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or carer (with patient's agreement); and
- review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared.

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

These items will only be payable for the completion of one 3 Step Mental Health Process for each eligible patient per year, unless a further plan is clinically indicated by exceptional circumstances.

If a subsequent 3 step process 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 3 Step Mental Health Process was required to be provided within 12 months of another 3 Step Mental Health Process.

The 3 Step Mental Health Process must include three steps, 1) assessment, 2) preparation of a mental health plan and 3) review of the mental health plan. Multiple consultations may be required for any or all steps.

All consultations conducted as part of the 3 Step Mental Health Process must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

A.31.6 *Step 1* ***Assessment***

An assessment of a patient must include:

- taking a detailed biological, psychological and social history including the presenting complaint;
- conducting a mental state examination;
- conducting a risk assessment;
- a diagnosis and/or formulation; and
- the administration of an outcome tool, except where it is considered clinically inappropriate.

A formulation is important for the development of a mental health plan and includes an assessment of the biological, psychological and social factors predisposing, precipitating, perpetuating and/or protecting against a mental health problem.

In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and the review stages of the 3 Step Mental Health Process, except where it is considered clinically inappropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

Recommended Outcome Tools

- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)
- Health of the Nation Outcome Scales (HoNOS)

Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek the appropriate education and training.

It should be noted that the outcome tools referred to above are not diagnostic tools.

Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment or components thereof (subject to patient agreement).

Consultations conducted as part of Step 1 (Assessment) should be billed under the normal attendance items.

A.31.7 *Step 2* ***Mental Health Plan***

Preparation of the mental health plan should be in consultation with the patient and/or carer (with agreement from the patient). A written copy of the mental health plan must be provided to the patient and/or carer (with agreement from the patient) where appropriate. Additionally a copy of the mental health plan must be kept in the patient's medical records.

If an assessment shows that it may be clinically appropriate to involve other health professionals in the patient's care it may be appropriate to prepare a multidisciplinary care plan. An Enhanced Primary Care (EPC) multidisciplinary care plan item (See Items 720 - 730) may be claimed if the preparation of the mental health plan fulfils the conditions required for the EPC care plan. (See Note A21.5).

The development of a mental health plan must include:

- discussion with the patient about the mental health formulation and/or diagnosis;
- discussion with the patient on treatment options including appropriate support services;
- provision of psycho-education;

- the written mental health plan must include a plan for treatment of the assessed mental health disorder/s and crisis intervention; and
- a plan for relapse prevention, if appropriate at this stage.

Treatment options could include psychological and pharmacological treatments, referral and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Consultations conducted as part of Step 2 (Mental Health Plan) should be billed under the normal attendance items.

A.31.8 *Step 3* ***Review of Mental Health Plan***
This step must occur a minimum of 4 weeks and a maximum of 6 months after the completion of step 2, the preparation of a mental health plan.

The review stage must include:
- a review of the patient's progress against the goals outlined in the mental health plan;
- modification of the mental health plan if required;
- check, reinforce and expand education;
- a plan for relapse prevention if not previously provided; and
- re-administration of the outcome tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that there may be further consultations between the patient and the GP.

Step 3 should be billed under the appropriate item listed in Group A18 or Group A19 of the Medicare Benefits Schedule Book which list - Professional Attendances - which will initiate the payment of an incentive directly to the practitioner through the PIP, in addition to attracting a Medicare rebate.

T8.17 Procedures on the Abdominal viscera (Item 30375)
T8.17.1 Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Item 30375 covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T8.19 Revision of Gastric reduction, gastroplasty or bypass
T8.19.1 Revision of a gastric procedure, for example to correct misplacement of the gastric band or other adverse effects of the initial surgery, involves complete reversal of the initial surgery immediately followed by another reduction, gastroplasty or bypass procedure. For revision, item 30514 can be claimed with either item 30511 or 30512, whichever is relevant. For cases where division of adhesions exceeds 45 minutes either item 30378 (laparotomy) or item 30393 (laparoscopy) can also be claimed.

T8.22 Removal of Skin Lesions (Items 31200 31355)
T8.22.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31200 to 31240.
T8.22.2 The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.
T8.22.3 Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.
T8.22.4 Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.
T8.22.5 A practitioner providing the first treatment episode for a primary BCC/SCC must use the appropriate item from the following: 31255; 31260; 31265; 31270; 31275; 31280; 31285; or 31290.

T8.22.6 Where residual BCC/SCC remains following an initial excision of a primary lesion and the same practitioner is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31256; 31261; 31266; 31271; 31276; 31281; 31286 or 31291.
T8.22.7 Where residual BCC/SCC remains following an initial excision of a primary lesion and a practitioner other than the practitioner that performed the previous excision is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31257; 31262; 31267; 31272; 31277; 31282; 31287 or 31292.
T8.22.8 Where a BCC/SCC was removed and complete excision of the lesion was confirmed, but a BCC/SCC has recurred at the primary site, then the items providing for recurrent BCC/SCC would usually apply.
T8.22.9 A practitioner excising a recurrent BCC/SCC of the head or neck and who is a specialist in the practice of his or her specialty or a practitioner other than the practitioner who provided previous treatment (where the lesion was removed by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy) must use item 31295.
T8.22.10 A practitioner excising a recurrent BCC/SCC from an area other than the head or neck or who otherwise does not meet the criteria as described under item 31295 must use the appropriate item from the following 31258; 31263; 31268; 31273; 31278; 31283; 31288 or 31293.
T8.22.11 For the purpose of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.
T8.22.12 Definitive surgical excision for items 31300 to 31335 is defined as "surgical removal with an adequate margin and, as a result, no further surgery is indicated at the site of the primary tumour".
T8.22.13 It will be necessary for practitioners to retain copies of histological reports.
T8.22.14 Items 31245 and 31250 do not cover shave excision.

T8.82 Breast Ptosis (Items 45556, 45557 and 45558)
T8.82.1 For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.
T8.82.2 Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove. Claims for benefits should be accompanied by full clinical details including colour photographs including an anterorlateral view. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. 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 8.6 of the General Explanatory Notes.) These items are payable only once per patient.

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

GROUP I2 COMPUTED TOMOGRAPHY
Items 56549 and 56551 have been included in the Medicare Benefits Schedule (MBS) for a limited period of two years and pending the outcome of an assessment of the procedure by the Medical Services Advisory Committee (MSAC). For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.

GROUP I3 DIAGNOSTIC RADIOLOGY
Sub-group 1 Radiological examination of extremities

Hand and wrist combination X-ray
An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

SUMMARY OF CHANGES PATHOLOGY SERVICES TABLE

Removal of episode from PST items
The term 'episode', where it implies the item, has been removed from the following item descriptors: 65072, 66539, 66626, 66655, 66659, 66669, 66670, 66672, 66673, 66750, 69378, 69381, 69382, 69442, 69443, 69444, 69445, 71073, 71075, 71077, 71079, 71127, 71135, 71137 and 73523. The word 'episode' is used in the rules of interpretation for the Pathology Services Table and in some item descriptors with a different application. Removing

'episode' from the item descriptors avoids any ambiguity that may arise by having two applications of the term 'episode'.

Group P2 - Chemical
There has been a minor change to items 66518 and 66519 to clarify those laboratory procedures that use blood specimens (plasma, serum or whole blood) for the quantitative measurement of creatine kinase isoenzyme, troponin or myoglobin can be claimed under this item.

Group P3 - Microbiology
There has been a minor word change to item 69336 to clarify that concentration techniques must be used to claim this item.

Group P7 - Genetics
Item 73305 (a southern blot test for fragile X mutation) is a pathologist determinable test following a request for item 73300 (a nucleic acid amplification test to detect fragile X mutation). The item descriptor states that item 73305 can only be claimed when the results in item 73300 are inconclusive. Making item 73305 pathologist determinable ensures that the pathology provider does not need a further request form from the treating practitioner for item 73305 to be eligible for Medicare benefits. This is described in an additional point (c) to explanatory note PA.2.2 (ii).

> **PA.2.2** ***Services Where Request Not Required***
> A written request is not required for -
> (i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;
>
> (ii) a pathologist-determinable service. A pathologist-determinable service is a pathology service :
> (a) that is specified rendered by or on behalf of an Approved Pathology Provider for a person who is a patient of that Approved Pathology Provider who has determined that the service is necessary; or
> (b) that is specified in only one of immunohistochemistry items 72846, 72847 or 72848 or immunocytochemistry items 73059, 73060 or 73061 or electronmicroscopy items 72851 or 72852 and is considered necessary by the Approved Pathology Provider as a consequence of information resulting from a pathology service contained in tissue examination items 72813 - 72836, cytology items 73045 - 73051 or tissue examination items 72813 - 72836 respectively; or
> (c) that is specified in item 73305 and is considered necessary by the Approved Pathology Provider as a consequence of information resulting from a pathology service contained in item 73300.
>
> Please note: a written request is required for a service contained in items 72813 to 72836 and items 73045 to 73051 and item 73300.

Rule 4 (1) (a)
A change to rule 4 (1) (a) has been made to avoid any ambiguity regarding the ability for all claimable items to be claimed in each of the 6 occasions that a specimen may be taken.

> **4. (1)** Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66515, 66584 or 66800, if:
> (a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and
> (b) the service is rendered to an inpatient in a hospital; and
> (c) in order to render the service, an approved pathology practitioner who is a recognised pathologist has to arrange for a member of the laboratory staff of the approved pathology authority concerned to undertake duties in respect of the service that are in addition to the usual duties of the staff member; and
> (d) the account for the service is endorsed 'Rule 3 Exemption'.

SUMMARY OF CHANGES

The 1 May 2005 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:-

†	new item
‡	amended description
□	benefit paid at100% of Schedule fee
♦	incorrectly printed benefits in 1 November 2004 MBS

New items

291	293	2497	2598	10999	30492	30495	31256	31257	31258	31261
31262	31263	31266	31267	31268	31271	31272	31273	31276	31277	31278
31281	31282	31283	31286	31287	31288	31291	31292	31293	35331	35360
35361	35362	35363	35568	35570	35571	35573	35577	35578	35595	35597
36605	36607	36608	36650	56549	56551					

Deleted items

35567	35576	35580	35584	35587	35590	35593	35600			

Amended description

2501	2503	2504	2506	2507	2509	2517	2574	2600	2603	2606
2610	2613	2616	2620	2704	11820	14106	14124	14218	30195	30375
30403	30405	30440	30451	30514	31255	31260	31265	31270	31275	31280
31285	31290	31295	35617	35618	39125	39126	39127	39128	39133	57512
57515	65072	66518	66519	66539	66626	66655	66659	66669	66670	66672
66673	66750	69336	69378	69381	69382	69442	69443	69444	69445	71073
71075	71077	71079	71127	71135	71137	73523				

Benefit paid at 100% of Schedule fee

2497	2501	2503	2504	2506	2507	2509	2517	2574	2598	2600
2603	2606	2610	2613	2616	2620	2704	10999			

Benefits printed incorrectly in 1 November 2004 MBS

61348	61360	61381	61383	61434

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 2005 and continues beyond that date, the old (1 November 2004) 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.

GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PSYCHIATRIST, REFERRED PATIENT ASSESSMENT AND MANAGEMENT

Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) where the attendance is initiated by that medical practitioner and where the consultant psychiatrist provides the referring medical practitioner with an assessment and management plan to be undertaken by that medical practitioner in general practice for the patient, where clinically appropriate.

An attendance of more than 45 minutes duration at consulting rooms during which: -

- An outcome tool is used where clinically appropriate
- A mental state examination is conducted
- A psychiatric diagnosis is made
- The consultant psychiatrist decides that the patient can be appropriately managed by the referring medical practitioner without the need for ongoing treatment by the psychiatrist
- A 12 month management plan, appropriate to the diagnosis, is provided to the referring medical practitioner which must:
  a) comprehensively evaluate biological, psychological and social issues;
  b) address diagnostic psychiatric issues;
  c) make management recommendations addressing biological, psychological and social issues; and
  d) be provided to the medical practitioner within two weeks of completing the assessment of the patient.
- The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)
- The diagnosis and management plan is communicated in writing to the referring medical practitioner

Not being an attendance on a patient in respect of whom, in the preceeding 12 months, payment has been made under this item

† 291 *(See para A.15 of explanatory notes to this Category)*
Fee: $218.15 **Benefit:** 85% = $185.45

CONSULTANT PSYCHIATRIST, REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT

Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice.

An attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which:

- An outcome tool is used where clinically appropriate
- A mental state examination is conducted
- A psychiatric diagnosis is made
- A management plan provided under Item 291 is reviewed and revised
- The reviewed managment plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)
- The reviewed management plan is communicated in writing to the referring medical practitioner

Being an attendance on a patient in respect of whom, in the preceeding 12 months, payment has been made under item 291, payable no more than once in any 12 month period

† 293 *(See para A.15 of explanatory notes to this Category)*
Fee: $136.95 **Benefit:** 85% = $116.45

GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS

SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN

LEVEL 'A'

Professional attendance involving taking a short patient history and, if required, limited examination and management

AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.

SURGERY CONSULTATION

†
(Professional attendance at consulting rooms)
□
(See para A.28 of explanatory notes to this Category)
2497 **Fee:** $14.10 **Benefit:** 100% = $14.10

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 at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.

SURGERY CONSULTATION

‡
(Professional attendance at consulting rooms)
□
(See para A.28 of explanatory notes to this Category)
2501 **Fee:** $30.85 **Benefit:** 100% = $30.85

OUT-OF-SURGERY CONSULTATION

(Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999.
‡
(See para A.28 of explanatory notes to this Category)
□
2503 **Derived Fee:** The fee for item 2501, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $1.55 per patient

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 at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.

SURGERY CONSULTATION

‡
(Professional attendance at consulting rooms)
□
(See para A.28 of explanatory notes to this Category)
2504 **Fee:** $58.55 **Benefit:** 100% = $58.55

OUT-OF-SURGERY CONSULTATION

(Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999.
‡
(See para A.28 of explanatory notes to this Category)
□
2506 **Derived Fee:** The fee for item 2504, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $1.55 per patient

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 at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.

SURGERY CONSULTATION

‡ (Professional attendance at consulting rooms)
□ *(See para A.28 of explanatory notes to this Category)*
2507 **Fee:** $86.20 **Benefit:** 100% = $86.20

OUT-OF-SURGERY CONSULTATION

(Professional attendance at a place other than consulting rooms). This item cannot be claimed in conjunction with item 10999. (See para A.28 of explanatory notes to this Category)
‡ **Derived Fee:** The fee for item 2507, plus $21.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $1.55 per patient
□
2509

SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH DIABETES MELLITUS

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 every 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
-	Measure blood pressure:	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 every 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

* Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight.

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)
□ *(See para A.29 of explanatory notes to this Category)*
2517 **Fee:** $30.85 **Benefit:** 100% = $30.85

SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS

Note: Benefits included in Subgroup 4, A18 or A19, are payable for one 3 Step Mental Health Process per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated.

At a minimum the 3 Step Mental Health Process must include:

- at least 2 consultations of more than twenty minutes each for a patient with an assessed mental health disorder;
- at least 2 of the consultations to have been planned visits;
- an assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement);
- a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and
- utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate.

The 3 Step Mental Health Process can only be provided by a general practitioner, who practices in general practice and has been notified to the HIC as having the required credentials.

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 requirements of the 3 Step Mental Health Process.

SURGERY CONSULTATION

‡ (Professional attendance at consulting rooms)

□ *(See para A.31 of explanatory notes to this Category)*

2574 **Fee:** $58.55 **Benefit:** 100% = $58.55

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

SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN

SURGERY CONSULTATIONS

(Professional attendance at consulting rooms)

BRIEF CONSULTATION of not more than 5 minutes duration

AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999.

† □ *(See para A.28 of explanatory notes to this Category)*

2598 **Fee:** $11.00 **Benefit:** 100% = $11.00

	SURGERY CONSULTATIONS (Professional attendance at consulting rooms)
‡ □ 2600	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00
‡ □ 2603	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00
‡ □ 2606	**PROLONGED CONSULTATION** of more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00
	OUT-OF-SURGERY CONSULTATIONS (Professional attendance at a place other than consulting rooms)
‡ □ 2610	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** 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
‡ □ 2613	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** 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
‡ □ 2616	**PROLONGED CONSULTATION** of more than 45 minutes duration AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with item 10999. *(See para A.28 of explanatory notes to this Category)* **Derived Fee:** 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

	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
	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 every 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 - Measure blood pressure: — 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 every 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 * Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight. **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration
‡ □ 2620	AND which completes the requirements for a full year of care of a patient with established diabetes mellitus. *(See para A.29 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00

	SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS
	Note: Benefits included in Subgroup 4, A18 or A19, are payable for one service per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated. At a minimum the 3 Step Mental Health Process must include: - at least 2 consultations of more than twenty minutes each for a patient with an assessed mental health disorder; - at least 2 of the consultations to have been planned visits; - an assessment and formulation or diagnosis of the mental health disorder/s; - provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement); - a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and - utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate. The 3 Step Mental Health Process can only be provided by a medical practitioner (not including a general practitioner, a specialist or consultant physician), who practices in general practice and has been notified to the HIC as having the required credentials. **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration
‡ □ 2704	AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.31 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00

GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER

Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, if:
(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and
(b) the service is provided at, or from, a practice location in a regional, rural or remote area; and
(c) the person is not an admitted patient of a hospital or approved day hospital facility.

† This item cannot be claimed with items 2497- 2509 and 2598-2616
□ *(See para M2 of explanatory notes to this Category)*
10999 **Fee:** $10.20 **Benefit:** 100% = $10.20

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL

CAPSULE ENDOSCOPY to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if:

(a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and
(b) the patient to whom the service is provided:
  (i) is aged 10 years or over; and
  (ii) has recurrent or persistent bleeding; and
  (iii) is anaemic or has active bleeding; and
(c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and
(d) the service is performed within 6 months of the upper gastrointestinal endoscopy and colonoscopy

‡ *(See para D1.21 of explanatory notes to this Category)*
11820 **Fee:** $1,730.25 **Benefit:** 75% = $1,297.70 85% = $1,670.25

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 12 - DERMATOLOGY

LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm^2 (Anaes.)

‡ *(See para T1.11 of explanatory notes to this Category)*
14106 **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00

LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - ***where a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes.)

‡ *(See para T1.11 of explanatory notes to this Category)*
14124 **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00

SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES

IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain

‡ 14218 **Fee:** $83.05 **Benefit:** 75% = $62.30 85% = $70.60

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
‡ 30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
‡ 30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $442.25 **Benefit:** 75% = $331.70
‡ 30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $442.25 **Benefit:** 75% = $331.70
‡ 30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $776.30 **Benefit:** 75% = $582.25
‡ 30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $446.60 **Benefit:** 75% = $334.95 85% = $386.60
‡ 30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $227.10 **Benefit:** 75% = $170.35 85% = $193.05
† 30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed) **Fee:** $668.00 **Benefit:** 75% = $501.00
† 30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture **Fee:** $668.00 **Benefit:** 75% = $501.00
‡ 30514	MORBID OBESITY, surgical reversal by any method of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $1,306.00 **Benefit:** 75% = $979.50

‡ 31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $187.85 **Benefit:** 75% = $140.90 85% = $159.70
† 31256	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where previous excision was performed by the same practitioner*, where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $187.85 **Benefit:** 75% = $140.90 85% = $159.70
† 31257	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where *the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $187.85 **Benefit:** 75% = $140.90 85% = $159.70
† 31258	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where *the specimen excised is sent for histological examination and confirmation of malignancy has been obtained* - not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $187.85 **Benefit:** 75% = $140.90 85% = $159.70
‡ 31260	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **therapeutic surgical excision (other than shave excision) and suture *and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
† 31261	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
† 31262	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where performed by a practitioner other than the practitioner who provided the previous treatment,* where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
† 31263	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment,* where the tumour size is more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained* - not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70

‡ 31265	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
† 31266	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
† 31267	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
† 31268	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
‡ 31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $219.15 **Benefit:** 75% = $164.40 85% = $186.30
† 31271	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $219.15 **Benefit:** 75% = $164.40 85% = $186.30
† 31272	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $219.15 **Benefit:** 75% = $164.40 85% = $186.30
† 31273	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $219.15 **Benefit:** 75% = $164.40 85% = $186.30

‡ 31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.90 **Benefit:** 75% = $190.45 85% = $215.85
† 31276	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.90 **Benefit:** 75% = $190.45 85% = $215.85
† 31277	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.90 **Benefit:** 75% = $190.45 85% = $215.85
† 31278	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.90 **Benefit:** 75% = $190.45 85% = $215.85
‡ 31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $132.20 **Benefit:** 75% = $99.15 85% = $112.40
† 31281	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $132.75 **Benefit:** 75% = $99.60 85% = $112.85
† 31282	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $132.75 **Benefit:** 75% = $99.60 85% = $112.85
† 31283	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items *31255* and *31265*,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment*****, where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $132.75 **Benefit:** 75% = $99.60 85% = $112.85

‡ 31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $180.75 **Benefit:** 75% = $135.60 85% = $153.65
† 31286	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $180.75 **Benefit:** 75% = $135.60 85% = $153.65
† 31287	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $180.75 **Benefit:** 75% = $135.60 85% = $153.65
† 31288	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31270, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $180.75 **Benefit:** 75% = $135.60 85% = $153.65
‡ 31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $208.65 **Benefit:** 75% = $156.50 85% = $177.40
† 31291	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $208.65 **Benefit:** 75% = $156.50 85% = $177.40
† 31292	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $208.65 **Benefit:** 75% = $156.50 85% = $177.40
† 31293	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31275, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $208.65 **Benefit:** 75% = $156.50 85% = $177.40
‡ 31295	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment*, removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $248.50 **Benefit:** 75% = $186.40 85% = $211.25

	SUBGROUP 3 - VASCULAR
† 35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure (Anaes.) **Fee:** $502.70 **Benefit:** 75% = $377.05
† 35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure but not the routine removal of catheters, cannulae or other similar devices (Anaes.) (Assist.) **Fee:** $702.70 **Benefit:** 75% = $527.05
† 35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure but not the routine removal of catheters, cannulae or other similar devices (Anaes.) (Assist.) **Fee:** $602.70 **Benefit:** 75% = $452.05
† 35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure but not the routine removal of catheters, cannulae or other similar devices (Anaes.) (Assist.) **Fee:** $502.70 **Benefit:** 75% = $377.05
† 35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure but not the routine removal of catheters, cannulae or other similar devices (Anaes.) (Assist.) **Fee:** $402.70 **Benefit:** 75% = $302.05

	SUBGROUP 4 - GYNAECOLOGICAL
† 35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $530.00 **Benefit:** 75% = $397.50
† 35570	ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $470.00 **Benefit:** 75% = $352.50
† 35571	POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $470.00 **Benefit:** 75% = $352.50
† 35573	ANTERIOR AND POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $705.00 **Benefit:** 75% = $528.75
† 35577	MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
† 35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
† 35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $980.00 **Benefit:** 75% = $735.00
† 35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,250.00 **Benefit:** 75% = $937.50
‡ 35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) **Fee:** $147.35 **Benefit:** 75% = $110.55 85% = $125.25 **Fee:** $184.95 **Benefit:** 75% = $138.75 85% = $157.25
	SUBGROUP 5 - UROLOGICAL
† 36605	URETERIC STENT insertion with removal of calculus from the pelvicalyceal system and/or ureter, through a nephrostomy tube (Anaes.) **Fee:** $586.00 **Benefit:** 75% = $439.50
† 36607	URETERIC STENT insertion with balloon dilatation of the pelvicalyceal system and/or ureter, through a nephrostomy tube (Anaes.) **Fee:** $586.00 **Benefit:** 75% = $439.50

† 36608	URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) **Fee:** $227.10 **Benefit:** 75% = $170.35
† 36650	NEPHROSTOMY TUBE, removal of, where the ureter has been stented with a double J ureteric stent and where the stent is left insitu (Anaes.) **Fee:** $127.00 **Benefit:** 75% = $95.25
	SUBGROUP 7 - NEUROSURGICAL
‡ 39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of - for connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $252.90 **Benefit:** 75% = $189.70
‡ 39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with analgesic, with or without programming of the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $307.05 **Benefit:** 75% = $230.30
‡ 39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER FOR PAIN, insertion of, for the management of chronic intractable pain (Anaes.) **Fee:** $401.90 **Benefit:** 75% = $301.45
‡ 39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion, and connection of pump to catheter and loading of reservoir with analgesic, with or without programming of the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $559.95 **Benefit:** 75% = $420.00
‡ 39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER for the management of chronic intractable pain, not being a service to which items 39125, 39126 or 39128 apply (Anaes.) **Fee:** $135.30 **Benefit:** 75% = $101.50
COMPUTED TOMOGRAPHY	**COMPUTED TOMOGRAPHY**
	GROUP I2 - COMPUTED TOMOGRAPHY
† 56549	COMPUTED TOMOGRAPHY OF COLON, following incomplete colonoscopy in the preceding 3 months, where the patient is referred by the specialist or consultant physician who performed the incomplete colonoscopy, not being a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
† 56551	COMPUTED TOMOGRAPHY OF COLON, where the patient is referred by a specialist or consultant physician and where (a) one of the following conditions is present: (i) fistulous disease (ii) obstructed colon (iii) megacolon and where (b) the request specifies the condition; not being a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
DIAGNOSTIC RADIOLOGY	**EXTREMITIES**
	GROUP I3 - DIAGNOSTIC RADIOLOGY
	SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES
‡ 57512	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) **Fee:** $40.50 **Benefit:** 75% = $30.40 85% = $34.45
‡ 57515	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) **Fee:** $54.00 **Benefit:** 75% = $40.50 85% = $45.90
NUCLEAR MEDICINE IMAGING	**NUCLEAR MEDICINE IMAGING**
	GROUP I4 - NUCLEAR MEDICINE IMAGING
♦ 61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $438.95 **Benefit:** 75% = $329.25 85% = $378.95

♦ 61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) **Fee:** $399.35 **Benefit:** 75% = $299.55 85% = $339.45
♦ 61381	GASTRIC EMPTYING STUDY, using single tracer (R) **Fee:** $568.65 **Benefit:** 75% = $426.50 85% = $508.65
♦ 61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) **Fee:** $618.75 **Benefit:** 75% = $464.10 85% = $558.75
♦ 61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $609.30 **Benefit:** 75% = $457.00 85% = $549.30
PATHOLOGY	**PATHOLOGY**
	GROUP P1 - HAEMATOLOGY
‡ 65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests **Fee:** $10.30 **Benefit:** 75% = $7.75 85% = $8.80
	GROUP P2 - CHEMICAL
‡ 66518	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 1 specimen in a 24 hour period **Fee:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
‡ 66519	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 2 or more specimens in a 24 hour period **Fee:** $40.85 **Benefit:** 75% = $30.65 85% = $34.75
‡ 66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - 1 of this item to a maximum of 2 in a 12 month period **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
‡ 66626	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 - 1 of this item to a maximum of 36 in a 12 month period **Fee:** $24.55 **Benefit:** 75% = $18.45 85% = $20.90
‡ 66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period **Fee:** $20.50 **Benefit:** 75% = $15.40 85% = $17.45
‡ 66659	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the followup of a PSA result which lies in the equivocal range of the particular method of assay used to determine the level - 1 of this item in a 12 month period **Fee:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15
‡ 66669	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
‡ 66670	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) **Fee:** $53.35 **Benefit:** 75% = $40.05 85% = $45.35
‡ 66672	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
‡ 66673	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 22) **Fee:** $53.35 **Benefit:** 75% = $40.05 85% = $45.35

‡ 66750	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE_3), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - 1 of this item in a pregnancy **Fee:** $40.45 **Benefit:** 75% = $30.35 85% = $34.40
	GROUP P3 - MICROBIOLOGY
‡ 69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period **Fee:** $33.65 **Benefit:** 75% = $25.25 85% = $28.65
‡ 69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy - 1 or more tests on 1 or more specimens **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
‡ 69381	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
‡ 69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
‡ 69442	Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation or the assessment of efficacy of antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69444 or 69445) - To a maximum 2 of this item in a 12 month period **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
‡ 69443	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if: (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; To a maximum of 1 of this item in a 12 month period **Fee:** $206.20 **Benefit:** 75% = $154.65 85% = $175.30
‡ 69444	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
‡ 69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69444) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 19) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90

	GROUP P4 - IMMUNOLOGY
‡ 71073	Quantitation of all 4 immunoglobulin G subclasses **Fee:** $108.00 **Benefit:** 75% = $81.00 85% = $91.80
‡ 71075	Quantitation of immunoglobulin E (total), 1 test. To a maximum of 2 of this item in a 12 month period **Fee:** $23.40 **Benefit:** 75% = $17.55 85% = $19.90
‡ 71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test. To a maximum of 6 of this item in a 12 month period **Fee:** $27.55 **Benefit:** 75% = $20.70 85% = $23.45
‡ 71079	Detection of specific immunoglobulin G or E antibodies to single or multiple potential allergens, 1 of this item to a maximum of 4 in a 12 month period **Fee:** $27.30 **Benefit:** 75% = $20.50 85% = $23.25
‡ 71127	Functional tests for lymphocytes - quantitation other than by microscopy of: (a) proliferation induced by 1 or more mitogens; or (b) proliferation induced by 1 or more antigens; or (c) estimation of 1 or more mixed lymphocyte reactions; including a test described in item 65066 or 65070 (if performed), 1 of this item to a maximum of 2 in a 12 month period **Fee:** $179.45 **Benefit:** 75% = $134.60 85% = $152.55
‡ 71135	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period **Fee:** $211.60 **Benefit:** 75% = $158.70 85% = $179.90
‡ 71137	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period **Fee:** $30.80 **Benefit:** 75% = $23.10 85% = $26.20
	GROUP P8 - INFERTILITY AND PREGNANCY TESTS
‡ 73523	Semen examination (other than post-vasectomy semen examination), including: (a) measurement of volume, sperm count and motility; and (b) examination of stained preparations; and (c) morphology; and (if performed) (d) differential count and 1 or more chemical tests; 1 of this item to a maximum of 4 in a 12 month period **Fee:** $42.50 **Benefit:** 75% = $31.90 85% = $36.15