The Australian Government
Department of Health and Ageing

Supplement to the

Medicare Benefits Schedule

Of 1 November 2005

Effective 1 May 2006

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 2005 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2006

This supplement provides details of changes to the 1 November 2005 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2005 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 $345.50 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 2006.

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 $500 for registered families in receipt of Family Tax Benefit (A) and concession card holders, or $1,000 for all other individuals and families is reached. These thresholds were increased with effect from 1 January 2006.

Individual and family safety net thresholds are calculated and monitored by Medicare Australia. 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 2006. 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:-

- Change to explanatory note A.23.21 (See below) - updated EPC referral form information.
- **Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits** - A minor amendment has been made to paragraph A.9.2 as a result of the introduction of a new health assessment item 716 which is a derived fee arrangement. The new paragraph should read:
  A.9.2 The number of patients seen should not include attendances which do not attract a Medicare rebate (eg public in-patients, attendances for normal after-care), or where a Medicare rebate is payable under an item other than these derived fee items (eg care planning, emergency after-hours attendance – first patient).
- Inclusion to explanatory note A.23.22 (See below) - inclusion of exercise physiologists (Item 10953, on 1 January 2006) under eligible allied health services.
- **Ophthalmology** - New item 109 has been introduced for the comprehensive eye examination of children aged 0-8 years inclusive, and developmentally delayed children aged 0-14 years inclusive, where the examination involves an additional level of complexity. The introduction of this item has required minor amendments to items 104 and 106 to prevent these items being claimed in association with item 109.
- **Consultant Psychiatrists** - A fee increase has been applied to Items 348, 350, 352 to encourage more psychiatrists to engage with carers of patients and provide a more appropriate remuneration for the service being provided.
- **Emergency Medicine** - The fees for items 501 to 536 have been increased to align emergency physicians' attendance items with the specialist attendance item structure.

- **Aboriginal and Torres Strait Islander Child Health Check -** Item 708 encourages prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality among Aboriginal and Torres Straight Islander children. See Note A.21.16 below.
- **Health Assessments for Refugees and Other Humanitarian Entrants** - Items 714 and 716 have been included to provide rebates for health assessments of refugees and other humanitarian entrants within 12 months of receiving residency or arrival (whichever is the later) in Australia. See Note A.21.71 below.
- **Case conference for geriatrician or rehabilitation physician -** Item 880 has been introduced for the attendance of consultant physicians in geriatric and rehabilitation medicine at multidisciplinary case conferences for hospital inpatients. See Note A.38 below.
- **Pain Medicine -** The Minister for Health and Ageing has agreed to recognise pain medicine as a medical speciality. Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996 and 3000, have been introduced for medical practitioners who are recognised as a Fellow of the Faculty of Pain Medicine, practising in the specialty of pain medicine. See Note A.33 below.
- **Palliative Medicine -** The Minister for Health and Ageing has agreed to recognise palliative medicine as a medical speciality. Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088 and 3093, have been introduced for medical practitioners who are recognised as a Fellow of the Australasian Chapter of Palliative Medicine, practising in the specialty of palliative medicine. See Note A.33 below.
- **Immunisation and wound management services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner. -** Two new items have been introduced. Item 10988, immunisation provided by a registered Aboriginal Health Worker on behalf of a medical practitioner (not including a specialist or consultant physician). Item 10989 - wound management service provided by a registered Aboriginal Health Worker on behalf of a medical practitioner (not including a specialist or consultant physician).
  New note M5 (See below) has been added to explain these items**.**
- **Immunisation provided by a practice nurse on behalf of a medical practitioner** - a minor amendment has been made to item 10993 to allow immunisation services to be provided by practice nurses in any location (except to an admitted patient in a hospital or day-hospital facility). The item cannot be used for mass immunisations.
- **Microwave (UHF radiowave) cancer therapy** - Following a recommendation of a National Health and Medical Research Council committee which reviewed this therapy in 2005:
  - Regulation 14 of the *National Health Insurance Regulations 1975* (services for which Medicare benefits are not payable) has been amended to include microwave (UHF radiowave) cancer therapy. This excludes claims for the treatment under any MBS items, including attendance items. General Explanatory Note 13.2.3 has been amended to state this. (See below).
  - Item 13915 (Administration of cytotoxic chemotherapy) has been amended to exclude the payment of benefits for the injection of drugs used in microwave cancer therapy.
- **Implantable Drug Delivery System for the treatment of severe chronic spasticity -** Items 14227, 14230, 14233, 14236, 14239 and 14242 have been introduced for the intrathecal administration of baclofen for the treatment of severe chronic spasticity where oral antispastic agents have failed or caused unacceptable side effects. See Note T1.14 below.
- **Radiation Oncology** - Five new items (15550, 15553, 15556, 15559, and 15562) have been introduced to cover the planning and simulation for three dimensional conformal radiotherapy. Explanatory notes T2.2.3, T2.2.4 and T2.2.5 have been added to reflect these new items. (See Below).
- **General** - Item 31200 for the excision of tumour, cyst, ulcer, scar has been amended to exclude the claiming of skin flap items 45200, 45203 and 45206 in association with this service. Note T86.4 and T86.5 have been amended to reflect this change. See below.
- **Vertebroplasty -** Items 35400 and 35402, which were introduced under a 3C Ministerial Determination on 1 November 2005 following a recommendation of the Medical Services Advisory Committee (MSAC), have been moved into the MBS on an interim basis. The indications covered are: painful osteoporotic vertebral compression fracture where the pain is uncontrolled by conservative medical therapy (35400); and, painful metastatic deposit or multiple myeloma in a vertebral body (35402). The items have also been identified as now eligible to attract an anaesthetic fee. See Note T8.41 below.
- **Selective Internal Radiation Therapy (SIRT) using SIR-Spheres -** Following a recommendation of the Medical Services Advisory Committee (MSAC), interim items 35404, 35406, 35408 have been introduced for the first line treatment of hepatic metastases secondary to colorectal cancer which are not suitable for resection or ablation, using SIRT with SIR-Spheres in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, and collection of survival data. Medicare funding for these items is

available for four years until May 2010, before which time MSAC will review the results of trials conducted in the intervening period.

- **Endometrial ablation -** Following a review by the Medical Services Advisory Committee that found second generation endometrial ablation techniques were as safe and effective as first-generation techniques, radiofrequency electrosurgery has been added to the list of ablation techniques covered under item 35616.
- **High energy transurethral microwave thermotherapy -** Following a recommendation of the Medical Services Advisory Committee, items 37230 and 37233 have been introduced for use of this procedure in patients with moderate to severe symptoms of benign prostatic hypertrophy.
- **Cardiac resynchronisation therapy -** Following a recommendation of the Medical Services Advisory Committee, items 38365, 38368 and 38654 have been introduced for use of this procedure in patients who have moderate to severe chronic heart failure, are in sinus rhythm and have a QRS duration greater than or equal to 120ms. (See Note T8.60 below).
- **Ophthalmology Lens Surgery -** From 1 May 2006, the 85% Medicare benefit has been retrospectively re-instated with effect 1 November 2005 for items 42698, 42701, 42702, 42703, 42707, 42710 and 42716 after revised advice from the Australian Medical Association and the Royal Australian and New Zealand College of Ophthalmologists regarding current practice.
- **Spine fracture/dislocation** - Items 47684, 47687, 47690 and 47693 have been amended to clarify that they cover treatment with immobilisation by callipers or halo.
- **Transurethral resection of the Prostate** – Item 37206 has been amended to correct a typographic error. This item now may be claimed as a continuation within 10 days of the procedure described by item 37207, rather than 37208.

A.21.16 ABORIGINAL AND TORRES STRAIT ISLANDER CHILD HEALTH CHECK (ITEM 708)

A.21.17 The purpose of this Child Health Check is to ensure that Aboriginal and Torres Strait Islander children receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

A.21.18 This item applies to an Aboriginal and/or Torres Strait Islander person who is less than 15 years old. It complements the existing health assessments, available to Aboriginal and Torres Strait Islander people aged 15 years and over.

A.21.19 The Child Health Check will be undertaken in the context of a number of existing activities that are undertaken for children by a range of care providers, particularly in the first year of life. The health check complements these activities, but does not replace them.

A.21.20 It is recommended that the Aboriginal and Torres Strait Islander Child Health Check be provided annually. However, to allow some flexibility in timing, a minimum period of 9 months has been set. This will also allow medical practitioners to provide health checks more frequently during the first few years of a patient's life. The Child Health Check should not replace existing routine neonatal and 6-8 week baby checks. An optimum time to commence the Child Health Check may be in the 4-6 month age group, as this is the age where growth faltering is more likely to occur.

A.21.21 Aboriginal and Torres Strait Islander children have higher rates of death, illness and hospitalisations than non-Indigenous children at all ages. Respiratory infections are the leading cause of hospitalisation for Aboriginal and Torres Strait Islander infants and children, and are a major cause of excess deaths. Sudden infant death syndrome, injuries and infectious diseases are also significant causes of excess deaths. Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to be born with a low birth weight and as a consequence are more at risk of associated illness. Aboriginal and Torres Strait Islander children have higher rates of otitis media than non-Indigenous children, and in some communities skin infections, gastrointestinal infections, malnutrition, acute rheumatic fever and rheumatic heart disease are significant causes of morbidity.

A.21.22 Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to be exposed to life stress events such as illness, hospitalisation, death of a close family member, family separation and family financial difficulties. They are also more likely to be cared for by a person with a long term health condition. Children in these circumstances are at higher risk of clinically significant emotional or behavioural difficulties. Assessment of life stress events and emotional and social wellbeing are an important component of the Aboriginal and Torres Strait Islander Child Health check.

A.21.23 An Aboriginal and Torres Strait Islander Child Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and determining what preventive health care, education and other assistance should be offered to that patient or the patient's parents/carer, to improve the patient's health and physical, psychological or social function.

A.21.24 This item does not apply to people who are in-patients of a hospital or day hospital facility. Practitioners should consider the applicability of other medical services, including other Enhanced Primary Care services, to ensure that the health needs of eligible patients as identified in the health check are followed up.
A.21.25 For the purposes of this item a person is an Aboriginal and/or Torres Strait Islander person if the person identifies himself or herself as being of Aboriginal and/or Torres Strait Islander descent, or is identified as such by their parent or carer. Patients or their parent or carer should be asked to identify their Aboriginal and/or Torres Strait Islander status for the purpose of these items, either verbally or by completing a form.
A.21.26 The Aboriginal and Torres Strait Islander Child Health Check should generally be undertaken by the patient's 'usual doctor', that is the medical practitioner, or a practitioner working in the medical practice or health service, who has provided the majority of services to the patient in the past twelve months, or who will provide the majority of services in the following twelve months.
A.21.27 Before the health check is commenced, the patient or their parent or carer must be given an explanation of the health check process and its likely benefits, and must be asked by the medical practitioner whether they consent to the health check being performed. Consent must be noted on the patient record.
A.21.28 When a medical practitioner undertakes a health check for an Aboriginal and/or Torres Strait Islander person, he or she should consider the results of any previous consultations and health checks for that person. It may therefore be appropriate to obtain and consider the patient's relevant medical records, including presentations and recurrent admissions, where these are available, before undertaking the health check.
A.21.29 The information collection component of the assessment may be completed by an Aboriginal/Torres Strait Islander health worker, nurse or other qualified health professional where:

(a) the patient's medical practitioner has initiated the collection of information by a third party, after the patient or their parent or carer has agreed to the Child Health Check and has agreed to a third party collecting information for the assessment;
(b) the patient or their parent or carer is told whether or not information collected about them for the health check will be retained by the third party; and
(c) the third party acts under the supervision of the practitioner.

The other components of the health check must include a personal attendance by the medical practitioner.

A.21.30 The medical practitioner should:
(a) be satisfied that the person collecting information for the Child Health Check has the necessary skills, expertise, training and cultural awareness;
(b) have established how the information is to be collected and recorded (including any forms used);
(c) set or approve the quality assurance procedures for the information collection;
(d) be consulted on any issues arising during the information collection; and
(e) review and analyse the information collected to prepare the report of the health check and communicate to the patient their recommendations about matters covered by the health check.

A.21.31 An Aboriginal and Torres Strait Islander Child Health Check must include:
(a) taking the patient's medical history;
(b) examining the patient;
(c) undertaking or arranging any required investigation;
(d) assessing the patient, using the information gained in the health check; and
(e) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

A.21.32 **HISTORY**

The health check must include the taking of a comprehensive patient medical history (if one does not already exist) or the updating of that history (if it already exists). This should include recording personal information relating to the patient – name, age and gender. It is also recommended that contact details are updated at each appointment and that alternative contact details for the patient are recorded.

Medical practitioners should also review information contained in the patient's child health record.

Mandatory Matters.

The following list of items comprises those items that should be included in the patient's history as a minimum. The history should be appropriate for the age of the patient.

History:

- Mother's pregnancy
- Birth and neo-natal period
- Breastfeeding,
- Weaning, food access and dietary history
- Physical activity
- Medical history including previous presentations, hospital admissions and medication use
- Relevant family medical history
- Immunisation status
- Vision and hearing (including neonatal hearing screening)
- Development (achievement of age-appropriate milestones)
- Family relationships, social circumstances and whether the patient is cared for by another person
- Exposure to environmental factors, including tobacco smoke
- Environmental**,** and living conditions (eg. overcrowding)
- Educational progress
- Stressful life events
- Mood (eg**,** depression and self harm risk**,**)
- Substance use
- Sexual activity
- Dental hygiene and access to dental services
- Other history as considered necessary by the practitioner/collector

A.21.33 **EXAMINATION**

In examining the patient, the practitioner should consider the following matters.

Mandatory matters:	< 2 years	2-3 years	4-9 years	10-14 years
Height and weight (plot and interpret growth curve/calculate BMI),	✓	✓	✓	✓
Newborn baby check if not previously completed	✓			
Vision (red reflex in newborn)	✓			
Ear examination (otoscopy)	✓	✓	✓	✓
Teeth and gums		✓	✓	✓
Optional matters in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.				
Trachoma check where indicated			✓	✓
Skin examination where indicated (scabies and skin sores)	✓	✓	✓	✓
Respiratory examination if indicated	✓	✓	✓	✓
Cardiac auscultation if indicated (congenital heart disease/rheumatic heart disease)	✓	✓	✓	✓
Developmental assessment (age appropriate milestones) where indicated	✓	✓	✓	✓
Assessment of parent-child interaction if indicated	✓	✓	✓	✓
Other examination as considered necessary by the practitioner	✓	✓	✓	✓

A.21.34 **Investigations**

Arrange or undertake investigations as clinically indicated and considered necessary by the practitioner in accordance with national or regional guidelines or specific regional needs.

Arrange haemoglobin testing for children at high risk of anaemia and ensure audiometry is conducted when required and at, or just before, school entry.

Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

A.21.35 **Assessment of Patient**

The overall assessment of the patient must be based on consideration of evidence from the patient history, examination and results of any investigations. Note that if tests have been ordered but results are not yet available, the practitioner may choose to either complete the health check and review the test results as opportunity arises in a subsequent consultation, or defer completion of the health check until the results are available. In either case the practitioner should ensure that any test results are reviewed and followed up as necessary.

A.21.36 **Intervention**

As part of the health check the practitioner must initiate intervention activity which he or she considers necessary to meet the identified needs of the patient.

The practitioner must assess risk factors and should discuss those risk factors with the patient or their parent or carer. The practitioner should provide or arrange for preventive health advice and intervention activity as indicated. This should be evidence-based, and may include arranging for activity and services by other local health and care providers.

Depending on age and condition, interventions may include:

- Treatment as required
- Follow-up as required
- Referral as required, including to dental providers
- Family-focussed intervention as appropriate
- Liaison with the patient's school and other service provider, as required
- Home visiting program referral
- Immunisation as recommended
- Advice on breast feeding, diet and nutrition
- SIDS prevention advice
- Injury prevention advice
- Parenting advice
- Sun protection advice
- Physical activity advice
- Safe sex advice
- Substance use (including tobacco) prevention and treatment
- Other interventions as considered necessary

The practitioner must develop a simple strategy for good health for the patient, including identification of required services and actions the patient should take, based on information from the health check. It should take account of any relevant previous advice given to the patient and the outcome of that advice. The strategy for good health should be developed in collaboration with the patient or their parent or carer and must be documented in the report about the health check.

The health check must also include keeping a record of the health check, and offering the patient or their parent or carer a written report about the health check, with recommendations about matters covered by the health check, including a simple strategy for the good health of the patient. The practitioner should ensure that this is communicated in a way that is understood by, and acceptable to the patient or their parent or carer.

In circumstances where the patient's usual practitioner or practice has not undertaken the health check, a copy of the health check report should be forwarded to that medical practitioner or practice, with the patient's consent.

If not already in place, it is recommended that practitioners establish a patient information register and recall system for their patients seeking a health check, and remind registered patients when their next health check is due.

A.21.71 Health Assessments for Refugees and Other Humanitarian Entrants (Items 714 and 716)

The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months

of arrival). Some new refugees and other humanitarian entrants may have little experience of western health care systems; some may not know what a General Practitioner is or does. Some may have complex and unusual conditions as a result of their area of origin or living conditions prior to arrival in Australia, where communicable diseases such as tuberculosis, hepatitis, parasitic infections and human immunodeficiency virus (HIV) and other sexually transmitted infections (STI) may be endemic. Many will have been exposed to war, famine, repression, torture and/or extreme poverty.

A.21.72 The aim of the assessment is to develop a detailed history and undertake a physical examination of the patient to identify immediate and long term health care needs and to initiate treatment. Patients can also be introduced to preventative health care in Australia, in particular immunisation, maternal and child health care and breast and cervical screening.

A.21.73 The health assessment complements other Medicare Benefits Schedule items for services that medical practitioners can provide, including normal consultations and enhanced primary care items for ongoing management of patients with chronic conditions.

A.21.74 A maximum of one Medicare rebate is payable for a health assessment per refugee or other humanitarian entrant.

A.21.75 For the purpose of this item, the health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services; this includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

- Offshore Refugee Category including:
    - 200 Refugee
    - 201 In Country Special Humanitarian
    - 203 Emergency rescue
    - 204 Women at Risk
- Offshore – Special Humanitarian Program
    - 202 Global Special Humanitarian
- Offshore – Temporary Humanitarian Visas (THV) including:
    - 447 Secondary Movement Offshore Entry Temporary
    - 451 Secondary Movement Relocation Temporary
    - 786 Temporary Humanitarian Concern
- Onshore Protection Program including:
    - 866 Permanent Protection Visa (PPV)
    - 785 Temporary Protection Visa (TPV)

A.21.76 Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132 011, with the patient present, to check eligibility.

A.21.77 This item does not apply to in-patients of a hospital or day hospital facility or care recipients in residential aged care facilities.

A.21.78 A health assessment means an assessment of a patient's health and physical, psychological and social function and whether preventative health care, education and other assistance should be offered to the patient, to improve that person's health and physical, psychological and social function.

A.21.79 The health assessment is a voluntary service; patients should be given an explanation of the health assessment process and its likely benefits before commencing the assessment. The patient's consent to a health assessment should be obtained as per normal practice for obtaining consent to medical services and noted on the patient record.

A.21.80 The medical practitioner and patient can use the services of a translator by accessing the Commonwealth Government's Translating and Interpreting Services (TIS) and the Doctors Priority Line. To be eligible for fee-free TIS and Doctors Priority Line, the medical practitioner must be in a private practice and provide a Medicare service to patients who do not speak English and are permanent residents.

A.21.81 Where the patient has a proposer the medical practitioner may find it useful to consider having them present for the health assessment or components of the health assessment (subject to the patient's agreement). The patient's proposer may be able to provide useful information on matters such as physical, psychological and social function.

A.21.82 When conducting a health assessment, where available, the medical practitioner should consider the results of any previous health checks that may have been undertaken as part of Australia's entry requirement.

A.21.83 The information collection component of the health assessment may be completed by a nurse or other qualified health professional where:

(a) the patient's medical practitioner has initiated the collection of information by a third party, after the patient has agreed to the health assessment and has agreed to a third party collecting information for the assessment;

(b) the patient is told whether or not information collected about them for the health assessment will be retained by the third party; and
(c) the third party acts under the supervision of the medical practitioner.
The other components of the health assessment must include a personal attendance by the medical practitioner.

A.21.84 The medical practitioner should:
(a) be satisfied that the person collecting information has the necessary skills, expertise, training and cultural awareness;
(b) have established how the information is to be collected and recorded (including any forms used);
(c) set or approve the quality assurance procedures for the information collection;
(d) be consulted on any issues arising during the information collection; and
(e) review and analyse the information collected to prepare the report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.21.85 The health assessment must include keeping a record of the health assessment, and offering the patient a written report about the health assessment.
A.21.86 Any follow up work following completion of the health assessment should be treated as a different service. Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.
A.21.87 Where a component of the health assessment is conducted in consulting rooms (item 714) and a component is conducted in the patient's home, including by a third party acting under the supervision of the practitioner, (item 716) the latter item should be claimed.

A.21.88 **Content of the Health Assessment**
The health assessment should be undertaken in a culturally sensitive manner that is appropriate to the needs of the patient and must include:
(a) taking the patient's medical history;
(b) physically examining the patient;
(c) undertaking or arranging any required investigations;
(d) assessing the patient using the information gained at (a) to (c); and
(e) developing a management plan to address any issues and/or conditions and for the good health of the patient, including making/arranging any necessary interventions or referrals to allied health providers and specialists (noting that this may involve a cost to the patient).

The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient, however, practitioners, where clinically appropriate, should consider the following:

A.21.89 **History**
(a) Medical history: past/family history and perceived health status, medications, allergies, habits, chronic conditions.
(b) Social/refugee history: country of origin, preferred language, secondary/host countries, refugee detention camps, trauma issues.
(c) Immunisation history: for children consider full course and include on the Australian Child Immunisation Register; for teenagers consider measles, mumps and rubella vaccine, Hepatitis B, Meningococcal C; for adults consider serology and booster vaccines.
(d) Nutritional Assessment: malnutrition, vitamin deficiency or anaemia.
(e) Psychological history: depression, post traumatic stress disorder, grief, family separation, history of incarceration, torture, survivor guilt.

A.21.90 **Examination**
(a) Physical: height, weight, body mass index, blood pressure, temperature, percentile chart for children.
(b) Cardiac, respiratory and abdominal examination.
(c) Dentition: caries, gum disease, decreased dentition.
(d) Vision and hearing.
(e) Other: scars or injuries.

A.21.91 **Investigations as Required**
Arrange or undertake investigations as clinically indicated, consider the need for the following tests, in particular:

(a) Tests for iron deficiency, lipids, glucose, and hepatitis/rubella serology.
(b) Urine: urinary tract infection, Chlamydia with pregnancy.
(c) Others: faecal examination for parasites, serum vitamin D, HIV, chest x-ray and Mantoux skin test for tuberculosis.

Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

A.21.92 **Assessment of Patient**
The overall assessment of the patient should be based on the consideration of evidence from patient history, examination and results of any investigations. The list of diagnoses and/or problems from the health assessment should form the basis of any actions to be taken.

A.21.93 **Management Plan**
The management plan includes:
(a) planned follow-up of issues and/or conditions found in history, examination and investigations, including initiating intervention activity to meet the identified needs of the patient;
(b) initial recommendation of immunisation, diet, vitamins and medications;
(c) consideration of referrals to allied health professionals, approved torture and trauma professionals and/or specialist clinics; and
(d) consideration of contraception advice and review of pap smear/sexually transmitted disease screening.

A.21.94 **Additional matters of particular relevance to refugees and other humanitarian entrants.**
The health assessment will usually cover additional matters of particular relevance to humanitarian entrants. This may include dental treatment, allied health referrals, advice on breast feeding, diet and nutrition, injury prevention advice, parenting advice, safe sex advice, substance use (including tobacco) prevention and treatment, or other interventions as considered necessary.

A desktop guide - Caring for Refugee Patients in General Practice - is available on the RACGP website at www.racgp.org.au.

Allied health and dental care services
A.23.21 Medical practitioners may use one form to refer patients for single or multiple services of the same service type. If referring a patient for a single or multiple services of *different* service types (for example, one dietetic service and three podiatry services) a separate referral form will be needed for each service type.

Referral forms may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing the Department on (02) 6289 7120. Copies of completed referral forms signed by the servicing allied health professional or dentist are no longer required to accompany Medicare claims.

The format of the form may be modified to suit practice needs. However, its content must remain substantially the same as the original Department of Health and Ageing form. A Microsoft Word version of the form is available at the Department's website: **www.health.gov.au/strengtheningmedicare**

If GP's are concerned about the appropriateness of format/ or minor content changes, they may fax a copy of the modified form to the Department's EPC and Allied Health Section on (02) 6289 7120 for approval.

Eligible allied health services
A.23.22 Eligible allied health services are those provided by:
- Aboriginal health workers; audiologists; chiropodists; chiropractors; diabetes educators; dietitians; exercise physiologists, mental health workers; occupational therapists; osteopaths; physiotherapists; podiatrists; psychologists; and speech pathologists.

A.33 Attendance by a consultant physician or specialist practising in the specialty of Pain Medicine (2801, 2806, 2814, 2824, 2832, 2840) and Case conference by a consultant physician or specialist practising in the specialty of Pain Medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).
A.33.1 Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, apply only to a service provided by a recognised Fellow of the Faculty of Pain Medicine

Australian and New Zealand College of Anaesthetists, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).
A.33.2 The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.
A.33.3 Where the service provided to a referred patient is by a medical practitioner who is recognised as a pain medicine specialist and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

A.33.4 Attendance by a consultant physician or specialist practicing in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028) and Case conference by a consultant physician or specialist practicing in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).
A.33.5 Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, apply only to a service provided by a recognised Fellow of the Australasian Chapter of Palliative Medicine, Royal Australasian College of Physicians (FAChPM) in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).
A.33.6 General Practitioners who hold a FAChPM and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 725) or Team Care Arrangement items (723 and 727) for that patient. The referring practitioner is able to provide these services.
A.33.7 The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.
A.33.8 Where the service provided to a referred patient is by a medical practitioner who is recognised as a palliative medicine specialist and that service is a palliative medicine service, then the relevant items from the pain or palliative specialist group (3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

A.38 Case conference by consultant physicians in geriatric/rehabilitation medicine (Item 880)
A.38.1 Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a day-hospital or residential aged care facility) who is receiving one of the following types of specialist care:

- geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or
- rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

A.38.2 Both types of care are evidenced by multi-disciplinary management and regular assessments against a plan with negotiated goals and indicative time-frames. A case conference is usually held on each patient once a week throughout the patient's admission, usually as part of a regular scheduled team meeting, at which all the inpatients under the consultant physician's care are discussed in sequence.

The specific responsibilities of the coordinating consultant physician or specialist are defined as:

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

A.38.3 The multidisciplinary team participating in the case conference must include a minimum of three formal inpatient care providers from different disciplines, including at least two providers from different allied health disciplines (listed at dot point 2 of A24.7). The consultant physician or specialist is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner can be counted toward the minimum of three.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three formal inpatient care providers must be present for the whole of the case conference.

Prior informed consent must be obtained from the patient, or the patient's agent including informing the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

Item 880 is not payable more than once a week or on the same day as a claim for any of the physician discharge case conferencing items 830, 832, 834, 835, 837 and 838, in respect of a particular patient.

M.5 Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner.

Immunisation services provided by a registered Aboriginal Health Worker (item 10988)

M.5.1 Item 10988 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where an immunisation is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

M.5.2 Item 10988 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

M.5.3 A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

M.5.4 The registered Aboriginal Health Worker must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

M.5.5 The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

M.5.6 Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.

M.5.7 The immunisation must be performed by the registered Aboriginal Health Worker in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

M.5.8 Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

M.5.9 A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

M.5.10 All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

M.5.11 Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the registered Aboriginal Health Worker), the medical practitioner may also claim for the professional attendance they provide to the patient.

M.5.12 Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied (see explanatory note M.1).

Wound management services provided by a registered Aboriginal Health Worker (item 10989)

M.5.13 Item 10989 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

M.5.14 Item 10989 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

M.5.15 A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

M.5.16 The registered Aboriginal Health Worker must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.
M.5.17 The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

M.5.18 Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.
M.5.19 The medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.
M.5.20 Where a registered Aboriginal Health Worker provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.
M.5.21 The wound management must be performed by the registered Aboriginal Health Worker in accordance with the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.
M.5.22 All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.
M.5.23 Where the medical practitioner provides a professional attendance to the patient (in addition to the wound management service provided by the registered Aboriginal Health Worker), the medical practitioner may also claim for the professional attendance they provide to the patient.
M.5.24 Item 10991 can also be claimed in conjunction with item 10989 provided the conditions of both items are satisfied (see explanatory note M.1).

13.2 Where Medicare Benefits are not Payable

13.2.3 Regulations are currently in force to preclude the payment of Medicare benefits in the following circumstances:-

(h) professional services rendered for the purposes of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

T1.10 Cytotoxic chemotherapy administration (Item 13915)

T1.10.1 Following a recommendation of a National Health and Medical Research Council review committee in 2005, Medicare benefits are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

T1.14 Implantable Drug Delivery System for the treatment of severe chronic spasticity (Item 14227, 14230, 14233, 14236, 14239, 14242)

T1.14.1 Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

(a) of cerebral origin; or
(b) due to multiple sclerosis; or
(c) due to spinal cord injury; or
(d) due to spinal cord disease.

Items 14227 to 14242 should be used in accordance with these restrictions.

T2.2 Planning Services (Items 15500 – 15562)

T2.2.3 Items 15500 to 15533 (inclusive) are for the purpose of a planning episode for two dimensional conformal radiotherapy. Items 15550 to 15562 (inclusive) are for the purpose of a planning episode for three dimensional conformal radiotherapy.
T2.2.4 It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in the course of a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in the course of a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in the course of a planning episode.

T2.2.5 The organs at risk must be clinically appropriate and clinical notes must contain information to support the use of a particular organ at risk.

T8.8 Therapeutic dose of Yttrium 90 (Item 16003)

T8.8.1 These items cannot be claimed for selective internal radiation therapy (SIRT). See items 35404, 35406 and 35408 for SIRT using SIR-Spheres (yttrium-90 microspheres).

T8.14 Cryotherapy and Serial Curettage Excision (Items 30196 - 30203)

T8.14.1 In items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

T8.14.2 For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

T8.14.3 For the purposes of items 30196 to 30203 (inclusive), an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

T8.41 Vertebroplasty (Items 35400, 35402)

T8.41.1 Items 35400 and 35402 have been introduced on an interim basis following a recommendation of the Medical Services Advisory Committee (MSAC). The MSAC assessment of vertebroplasty showed that finding either bone oedema or gas cleft on a magnetic resonance image was the most effective way of confirming that vertebroplasty would be effective in relieving pain due to osteoporotic vertebral compression fractures; the absence of either of these findings on a magnetic resonance image is considered a contra-indication to vertebroplasty.

T8.42 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres (Items 35404, 35406, 35408)

T8.42.1 These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC). Medicare funding for these items is available for four years until May 2010, before which time MSAC will review the results of trials conducted in the intervening period. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

T8.60 Permanent cardiac synchronisation device (Items 38365, 38368, 38654)

T8.60.1 Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

T8.60.2 Item 38365 includes any device capable of cardiac resynchronisation including those that are also capable of defibrillation.

T8.86 Local Skin Flap - Definition

T8.86.4 Items where benefit for local skin flap repair (if indicated as above) is payable, include:
30023, 30180, 30186, 30269, 31205-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.
Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

T8.86.5 The following items are examples of where local flap repair would usually not be payable. If further advice is required, Medicare Australia should be contacted.
30026-30052, 30099-30114, 30165-30177, 31200, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

Group I2 - Computed Tomography

CT coronary angiography is a technology that has not yet been assessed by the Medical Services Advisory Committee. The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 have been amended to clarify that they are not to be used to image the coronary arteries.

Diagnostic Computed Tomography (CT) scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided:

· the CT scan is not solely used for the purposes of attenuation correction or anatomical correlation of any associated PET or SPECT scan; and
· the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

SUMMARY OF CHANGES – PATHOLOGY SERVICES TABLE

PX.1 ***Rules for the Interpretation of the Pathology Services Table***
The definition of 'recognised pathologists' has been amended to further clarify the process for recognition as a specialist in pathology.

Rule 4(2). Certain Pathology Tests Do Not Attract Medicare Benefits
Dot point (h) has been created to allow for the requests for multiple services for the quantitation of calcium, phosphate, magnesium, potassium, urea, creatinine and electrolytes in cancer patient who are receiving monthly biphosphonate infusions.

Group P1 – Haematology
Items 65168, 65174, 65200 and 66794 have been deleted from group P1 and transferred to group P7 – genetics.

Group P3 – Microbiology
Item 69486 has been amended to provide access to human papillomavirus testing for patients currently undergoing annual cytological review for the follow-up of previously treated high grade intraepithelial abnormalities of the cervix. Item 69364 has been amended to include 'or microbial antigen'.

Group P4 - Immunology
Items 71146 has been amended to clarify any ambiguity regarding the claiming of a total white cell count.

Group P7 - Genetics
Items 73308, 73311, 73314 and 73317 have been created to replace items transferred from Group P1. Item 73320 has been created for detection of HLA-B27 by nucleic acid amplification techniques.

PB.1.1 ***Form of Request***
(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:
(c) a public patient in a recognised hospital;

PN.1 Health Insurance Regulations
Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: MSAC Secretariat, Australian Government, Department of Health and Ageing, MDP 106, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website - www.msac.gov.au

PX.1 Rules for the Interpretation of the Pathology Services Table

1. (1) In this table

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

4. (2) Rule 3 does not apply to any of the following pathology services:

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

(h) quantitative estimation of calcium, phosphate, magnesium, potassium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

(ii) the tests are performed within 6 months of the request; and

(iii) the account for the service is endorsed "Rule 3 Exemption".

SUMMARY OF CHANGES

The 1 May 2006 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
+	amended fee

New items

109	708	714	716	880	2801	2806	2814	2824	2832	2840
2946	2949	2954	2958	2972	2974	2978	2984	2988	2992	2996
3000	3005	3010	3014	3018	3023	3028	3032	3040	3044	3051
3055	3062	3069	3074	3078	3083	3088	3093	10988	10989	14227
14230	14233	14236	14239	14242	15550	15553	15556	15559	15562	35400
35402	35404	35406	35408	37230	37233	38365	38368	38654	73308	73311
73314	73317	73320								

Deleted items

65168	65174	65200	66794

Amended description

104	106	10993	13915	16003	31200	35616	37206	38353	38393	47684
47687	47690	47693	56301	56307	56341	56347	56801	56807	56841	56847
57001	57007	57041	57047	57350	57351	57355	57356	69364	69365	69486
71146										

Fee amended

348	350	352	501	503	507	511	515	519	520	530
532	534	536								

85% benefit re-instated effective 1 April 2006. Claims can be made retrospectively from 1 November 2005.

42698	42701	42702	42703	42707	42710	42716

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 2006 and continues beyond that date, the old (1 November 2005) 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.

Services that attract the 100% Medicare rebate – as at 1 May 2006

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, 708, 710, 712, 714, 716
Group A15 *(all items other than items 746, 749, 757, 768, 771, 773, 820-880)*	Multidisciplinary care plans and multidisciplinary case conferences	721, 723, 725, 727, 729, 731, 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	2497, 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	2598, 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, 10999
Group M5	Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner	10988, 10989

SPECIALIST	**SPECIALIST**
	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
‡ 104	**SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) **- INITIAL** attendance in a single course of treatment, not being a service to which item 106 or 109 applies **Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95
‡ 106	- **INITIAL SPECIALIST OPHTHALMOLOGIST ATTENDANCE** in a single course of treatment, being an attendance at which the sole service provided is refraction testing for the issue of a prescription for spectacles or contact lenses not being a service to which items 104, 109 or any of items 10801 to 10816 applies **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25
† 109	**INITIAL SPECIALIST OPHTHALMOLOGIST PAEDIATRIC ATTENDANCE** in a single course of treatment, being an attendance at which a comprehensive eye examination is performed on a child aged 8 years or under, or on a child aged 14 years or under with developmental delay, not being a service to which item 104, 106 or any of items 10801 to 10816 applies **Fee:** $111.20 **Benefit:** 75% = $83.40 85% = $94.55
CONSULTANT PSYCHIATRIST	**CONSULTANT PSYCHIATRIST**
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
+ 348	**CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a medical practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility *(See para A.17 of explanatory notes to this Category)* **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
+ 350	- An attendance of not less than 45 minutes duration *(See para A.17 of explanatory notes to this Category)* **Fee:** $151.45 **Benefit:** 75% = $113.60 85% = $128.75
+ 352	**CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT** Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period *(See para A.17 of explanatory notes to this Category)* **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
MEDICAL PRACTITIONER	**EMERGENCY MEDICINE**
	GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 1 - CONSULTATIONS
+ 501	**MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 1** Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making. *(See para A.35 of explanatory notes to this Category)* **Fee:** $29.60 **Benefit:** 75% = $22.20 85% = $25.20

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 2

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity.

\+ *(See para A.35 of explanatory notes to this Category)*

503 **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 3

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity.

\+ *(See para A.35 of explanatory notes to this Category)*

507 **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 4

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity.

\+ *(See para A.35 of explanatory notes to this Category)*

511 **Fee:** $118.85 **Benefit:** 75% = $89.15 85% = $101.05

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 5

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity.

\+ *(See para A.35 of explanatory notes to this Category)*

515 **Fee:** $184.05 **Benefit:** 75% = $138.05 85% = $156.45

SUBGROUP 2 - PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed

-For a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient

\+ *(See para A.36 of explanatory notes to this Category)*

519 **Fee:** $126.50 **Benefit:** 75% = $94.90 85% = $107.55

+ 520	-For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient *(See para A.36 of explanatory notes to this Category)* **Fee:** $243.05 **Benefit:** 75% = $182.30 85% = $206.60
+ 530	-For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient *(See para A.36 of explanatory notes to this Category)* **Fee:** $398.35 **Benefit:** 75% = $298.80 85% = $338.60
+ 532	-For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient. (See para A.36 of explanatory notes to this Category) Fee: $553.60 Benefit: 75% = $415.20 85% = $492.10
+ 534	-For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient (See para A.36 of explanatory notes to this Category) Fee: $709.10 Benefit: 75% = $531.85 85% = $647.60
+ 536	-For a period of 5 hours or more of total physician time spent with each patient. (See para A.36 of explanatory notes to this Category) Fee: $786.85 Benefit: 75% = $590.15 85% = $725.35

GROUP A14 - HEALTH ASSESSMENTS

† 708	**ABORIGINAL AND TORRES STRAIT ISLANDER CHILD HEALTH CHECK** Attendance by a medical practitioner, other than a specialist or a consultant physician, at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for a child health check of a patient who is of Aboriginal or Torres Strait Islander descent and aged 0 to 14 years inclusive - not being a child health check of a patient in respect of whom, in the preceding 9 months, a payment has been made under this item *(See para A.21 of explanatory notes to this Category)* **Fee:** $164.00 **Benefit:** 100% = $164.00
† 714	**HEALTH ASSESSMENT FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS** **Note: Benefits are payable on one occasion only for a service included in this item or item 716** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment of a patient that has been granted residency in Australia under the Humanitarian Program, not being a health assessment of a patient in respect of whom, a payment has been made under this item or **item 700, 702, 712 or 716.** Benefits are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later) *(See para A.21 of explanatory notes to this Category)* **Fee:** $195.50 **Benefit:** 100% = $195.50
† 716	**Note: Benefits are payable on one occasion only for a service included in this item or item 714** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** for a health assessment of a patient that has been granted residency in Australia under the Humanitarian Program, not being a health assessment of a patient in respect of whom, a payment has been made under this item or **item 700, 702, 712 or 714.** Benefits are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later) *(See para A.21 of explanatory notes to this Category)* **Derived Fee:** The fee for item 714, plus $22.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 714 plus $1.60 per patient.

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
	GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
	SUBGROUP 2 - CASE CONFERENCES
† 880	**CASE CONFERENCE - CONSULTANT PHYSICIAN IN GERIATRIC OR REHABILITATION MEDICINE** Attendance by a consultant physician in the practice of his or her specialty of GERIATRIC OR REHABILITATION MEDICINE, as a member of a case conference team, to **COORDINATE A CASE CONFERENCE ON AN ADMITTED HOSPITAL PATIENT** of at least 10 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.38 of explanatory notes to this Category)* **Fee:** $42.05 **Benefit:** 75% = $31.55
PAIN AND PALLIATIVE MEDICINE	**PAIN MEDICINE**
	GROUP A24 - PAIN AND PALLIATIVE MEDICINE
	SUBGROUP 1 - PAIN MEDICINE ATTENDANCES
† 2801	**MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL** Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner **- INITIAL** attendance in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $130.60 **Benefit:** 75% = $97.95 85% = $111.05
† 2806	- Each attendance (other than a service to which item 2814 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $65.40 **Benefit:** 75% = $49.05 85% = $55.60
† 2814	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
† 2824	**MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT** Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner **- INITIAL** attendance in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $158.50 **Benefit:**85% = $134.75
† 2832	- Each attendance (other than a service to which item 2840 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $95.85 **Benefit:** 85% = $81.50
† 2840	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $69.00 **Benefit:** 85% = $58.65
	SUBGROUP 2 - PAIN MEDICINE CASE CONFERENCES
† 2946	**CASE CONFERENCES - PAIN MEDICINE SPECIALIST** Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30

† 2949	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $180.60 **Benefit:** 75% = $135.45 85% = $153.55
† 2954	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60
† 2958	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
† 2972	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25
† 2974	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $189.30 **Benefit:** 75% = $142.00 85% = $160.95
† 2978	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
† 2984	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $180.60 **Benefit:** 75% = $135.45 85% = $153.55
† 2988	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60
† 2992	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
† 2996	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25

† 3000	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $189.30 **Benefit:** 75% = $142.00 85% = $160.95
	SUBGROUP 3 - PALLIATIVE MEDICINE ATTENDANCES
	MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a medical practitioner
† 3005	**- INITIAL** attendance in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $130.60 **Benefit:** 75% = $97.95 85% = $111.05
† 3010	- Each attendance (other than a service to which item 3014 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $65.40 **Benefit:** 75% = $49.05 85% = $55.60
† 3014	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
	MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pallitive medicine, where the patient was referred to him or her by a medical practitioner
† 3018	**- INITIAL** attendance in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $158.50 **Benefit:** 85% = $134.75
† 3023	- Each attendance (other than a service to which item 3028 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $95.85 **Benefit:**85% = $81.50
† 3028	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.33 of explanatory notes to this Category)* **Fee:** $69.00 **Benefit:**85% = $58.65
	SUBGROUP 4 - PALLIATIVE MEDICINE CASE CONFERENCES
	CASE CONFERENCES - PALLITIVE MEDICINE SPECIALIST Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines
† 3032	*(See para A.33 of explanatory notes to this Category)* **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
† 3040	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $180.60 **Benefit:** 75% = $135.45 85% = $153.55
† 3044	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60

PAIN AND PALLIATIVE MEDICINE			PALLIATIVE MEDICINE
† 3051	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55
† 3055	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $137.90	**Benefit:** 75% = $103.45	85% = $117.25
† 3062	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $189.30	**Benefit:** 75% = $142.00	85% = $160.95
† 3069	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $120.35	**Benefit:** 75% = $90.30	85% = $102.30
† 3074	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $180.60	**Benefit:** 75% = $135.45	85% = $153.55
† 3078	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $240.70	**Benefit:** 75% = $180.55	85% = $204.60
† 3083	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55
† 3088	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $137.90	**Benefit:** 75% = $103.45	85% = $117.25
† 3093	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A.33 of explanatory notes to this Category)* **Fee:** $189.30	**Benefit:** 75% = $142.00	85% = $160.95

	GROUP M5 – SERVICES PROVIDED BY A REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER
† 10988	Immunisation provided to a person by a registered Aboriginal Health Worker if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital or approved day hospital facility *(See para M5 of explanatory notes to this Category)* **Fee:** $10.40 **Benefit:** 100% = $10.40
† 10989	Treatment of a person's wound (other than normal aftercare) provided by a registered Aboriginal Health Worker if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital or approved day hospital facility *(See para M5 of explanatory notes to this Category)* **Fee:** $10.40 **Benefit:** 100% = $10.40
	GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER
‡ 10993	Immunisation provided to a person by a practice nurse if: (a) the immunisation is provided on behalf of, and under the suervision of, a medical practitioner; and (b) 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:** $10.40 **Benefit:** 100% = $10.40

	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES
‡ 13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin, or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone *(See para T1.10 of explanatory notes to this Category)* **Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90

	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
† 14227	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity *(See para T1.14 of explanatory notes to this Category)* **Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00
† 14230	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $257.95 **Benefit:** 75% = $193.50
† 14233	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 severe chronic spasticity (Anaes.) (Assist.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $313.20 **Benefit:** 75% = $234.90
† 14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $571.15 **Benefit:** 75% = $428.40
† 14239	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $138.00 **Benefit:** 75% = $103.50

MISCELLANEOUS	OTHER
† 14242	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $409.95 **Benefit:** 75% = $307.50
RADIATION ONCOLOGY	**COMPUTERISED PLANNING**
	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 5 - COMPUTERISED PLANNING
† 15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.2 of explanatory notes to this Category)* **Fee:** $570.00 **Benefit:** 75% = $427.50 85% = $508.50
† 15553	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.2 of explanatory notes to this Category)* **Fee:** $615.00 **Benefit:** 75% = $461.25 85% = $553.50
† 15556	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where: (a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and (b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and (c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and (d) dose volume histograms must be generated, approved and recorded with the plan; and (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and (f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.2 of explanatory notes to this Category)* **Fee:** $575.00 **Benefit:** 75% = $431.25 85% = $513.50
† 15559	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where: (a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or (c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.2 of explanatory notes to this Category)* **Fee:** $750.00 **Benefit:** 75% = $562.50 85% = $688.50

RADIATION ONCOLOGY		COMPUTERISED PLANNING
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. or (c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or (d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images † *(See para T2.2 of explanatory notes to this Category)* 15562 **Fee:** $970.00 **Benefit:** 75% = $727.50 85% = $908.50	
THERAPEUTIC NUCLEAR MEDICINE		**THERAPEUTIC NUCLEAR MEDICINE**
	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE	
	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) ‡ *(See para T8.8 of explanatory notes to this Category)* 16003 **Fee:** $563.05 **Benefit:** 75% = $422.30 85% = $501.55	
OPERATIONS		**GENERAL**
	GROUP T8 - SURGICAL OPERATIONS	
	SUBGROUP 1 - GENERAL	
	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies ‡ *(See para T8.24 of explanatory notes to this Category)* 31200 **Fee:** $29.45 **Benefit:** 75% = $22.10 85% = $25.05	
OPERATIONS		**VASCULAR**
	SUBGROUP 3 - VASCULAR	
	VERTEBROPLASTY, for the treatment of a painful osteoporotic vertebral compression fracture, where: (a) the patient to whom the service is provided has not had the pain arising from the vertebral compression fracture controlled by conservative medical therapy; and (b) diagnostic imaging has confirmed that vertebroplasty will be of benefit; in association with item 61109, 57341 or 57345, performed on an admitted patient in a hospital or day hospital facility. (Anaes.) † *(See para T8.41 of explanatory notes to this Category)* 35400 **Fee:** $571.90 **Benefit:** 75% = $428.95	
	VERTEBROPLASTY, for the treatment of a painful metastatic deposit or multiple myeloma in a vertebral body, in association with item 61109, 57341 or 57345, performed on an admitted patient in a hospital or day hospital facility. (Anaes.) † *(See para T8.41 of explanatory notes to this Category)* 35402 **Fee:** $571.90 **Benefit:** 75% = $428.95	
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. † *(See para T8.42 of explanatory notes to this Category)* 35404 **Fee:** $300.00 **Benefit:** 75% = $225.00	

† 35406	TRANS-FEMORAL CATHETERISATION OF THE HEPATIC ARTERY to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $703.85 **Benefit:** 75% = $527.90
† 35408	CATHETERISATION OF THE HEPATIC ARTERY via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $528.00 **Benefit:** 75% = $396.00
OPERATIONS	**GYNAECOLOGICAL**
	SUBGROUP 4 - GYNAECOLOGICAL
‡ 35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $389.10 **Benefit:** 75% = $291.85
OPERATIONS	**UROLOGICAL**
	SUBGROUP 5 - UROLOGICAL
‡ 37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37203, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or which had to be discontinued for medical reasons (Anaes.) **Fee:** $483.00 **Benefit:** 75% = $362.25
† 37230	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $901.90 **Benefit:** 75% = $676.45 85% = $840.40
† 37233	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207, 37230 which had to be discontinued for medical reasons (Anaes.) **Fee:** $483.00 **Benefit:** 75% = $362.25 85% = $421.50
OPERATIONS	**CARDIO-THORACIC**
	SUBGROUP 6 - CARDIO-THORACIC
‡ 38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy (Anaes.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $221.10 **Benefit:** 75% = $165.85
† 38365	PERMANENT CARDIAC SYNCRONISATION DEVICE, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $221.10 **Benefit:** 75% = $165.85
† 38368	PERMANENT TRANSVENOUS LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. Where the service includes right heart catheterisation and any associated venogram of left ventricular veins. Not being a service associated with a service to which items 38200 and 35200 apply (Anaes.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $1,059.85 **Benefit:** 75% = $794.90

† 38654	PERMANENT LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) (Assist.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $1,059.85 **Benefit:** 75% = $794.90
‡ 38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of - not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75

	SUBGROUP 15 - ORTHOPAEDIC
‡ 47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.) **Fee:** $651.90 **Benefit:** 75% = $488.95 85% = $590.40
‡ 47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45
‡ 47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation (Anaes.) (Assist.) **Fee:** $896.25 **Benefit:** 75% = $672.20
‡ 47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) **Fee:** $1,140.60 **Benefit:** 75% = $855.45

	GROUP I2 - COMPUTED TOMOGRAPHY
	CHEST AND UPPER ABDOMEN
‡ 56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $250.75
‡ 56307	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
‡ 56341	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05
‡ 56347	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70
	CHEST, ABDOMEN, PELVIS AND NECK
‡ 56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $466.55 **Benefit:** 75% = $349.95 85% = $405.05

‡ 56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $560.00 **Benefit:** 75% = $420.00 85% = $498.50
‡ 56841	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $233.35 **Benefit:** 75% = $175.05 85% = $198.35
‡ 56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $241.30
	BRAIN, CHEST AND UPPER ABDOMEN
‡ 57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $466.65 **Benefit:** 75% = $350.00 85% = $405.15
‡ 57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) **Fee:** $567.75 **Benefit:** 75% = $425.85 85% = $506.25
‡ 57041	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
‡ 57047	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) **Fee:** $283.90 **Benefit:** 75% = $212.95 85% = $241.35
	GROUP I2 - COMPUTED TOMOGRAPHY
	SPIRAL ANGIOGRAPHY
‡ 57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $448.50
‡ 57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $448.50

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY
‡ 57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55	
‡ 57356	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55	
PATHOLOGY		**PATHOLOGY**
	GROUP P3 - MICROBIOLOGY	
‡ 69364	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 26) **Fee:** $28.85 **Benefit:** 75% = $21.65 85% = $24.55	
‡ 69365	2 or more tests described in 69364 (Item is subject to rule 26) **Fee:** $36.10 **Benefit:** 75% = $27.10 85% = $30.70	
‡ 69486	A test for high risk human papillomaviruses (HPV) in a patient who: - has received excisional or ablative treatment for high grade squamous intraepithelial lesions (HSIL) of the cervix within the last two years; or - who within the last two years has had a positive HPV test after excisional or ablative treatment for HSIL of the cervix - is already undergoing annual cytological review for the follow-up of a previously treated HSIL. - to a maximum of 2 of this item in a 24 month period **Fee:** $64.00 **Benefit:** 75% = $48.00 85% = $54.40	
	GROUP P4 - IMMUNOLOGY	
‡ 71146	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pherisis collection **Fee:** $105.85 **Benefit:** 75% = $79.40 85% = $90.00	
	GROUP P7 - GENETICS	
† 73308	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $37.10 **Benefit:** 75% = $27.85 85% = $31.55	

† 73311	Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308 - 1 or more tests **Fee:** $37.10 **Benefit:** 75% = $27.85 85% = $31.55
† 73314	Characterisation of gene rearrangement by nucleic acid amplification in the diagnosis and monitoring of patients with laboratory evidence of: (a) acute myeloid leukaemia; or (b) acute promyelocytic leukaemia; or (c) acute lymphoid leukaemia; or (d) chronic myeloid leukaemia; each test to a maximum of 4 tests in a 12 month period **Fee:** $235.00 **Benefit:** 75% = $176.25 85% = $199.75
† 73317	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20) **Fee:** $37.10 **Benefit:** 75% = $27.85 85% = $31.55
† 73320	Detection of HLA-B27 by nucleic acid amplification **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10