The Australian Government
Department of Health and Ageing

Supplement to the

Medicare Benefits Schedule

Of 1 November 2006

Effective 1 May 2007

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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.

The latest Medicare Benefits Schedule information is available from *MBS Online* at http://www.health.gov.au/mbsonline

SUPPLEMENT TO 1 NOVEMBER 2006 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2007

This supplement provides details of changes to the 1 November 2006 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2006 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 $358.90 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 2007.

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 $519.50 for registered families in receipt of Family Tax Benefit (A) and concession card holders, or $1,039.00 for all other individuals and families is reached. These thresholds were increased with effect from 1 January 2007.

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 2007. 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:-

- **Mental Health - Psychiatry and Telepsychiatry** - The fees for item 299 has been increased to align rebates with similar psychiatry services requiring a home visit. Items 353 - 358 have been amended to remove the current geographical restrictions on the location of the provider enabling all eligible providers, regardless of location, to offer telepsychiatry services to rural and remote patients. Items 364 - 370 have been amended to remove the mandatory face-to-face consultation after every fourth telepsychiatry service and allow the provider to determine when a face-to-face consultation is required. The fees for items 353 - 358 have been increased to restore the 15% rebate differential between the telepsychiatry items and the face-to-face consultation items; The fees for items 367 and 369 have been increased to align rebates with similar face-to-face consultations.
- The **PIP mental health incentive items** 2574, 2575, 2577, 2578, 2704, 2705, 2707 and 2708 are no longer available after 30 April 2007, following the introduction of the new mental health care items for GPs on 1 November 2006 (items 2710 and 2712), as part of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative.
- **Assisted Reproductive Technologies** - Item 13251 has been introduced to cover intracytoplasmic sperm injection for the purposes of assisted reproductive technologies, for male factor infertility. New items have also been introduced to provide for transcutaneous sperm retrieval (item 37605) and surgical sperm retrieval by open approach (item 37606) performed for the purposes of intracytoplastic sperm injection.

This follows recommendations made by the Assisted Reproductive Technologies Review Committee and the Medicare Services Advisory Committee.

- **Antenatal Care** is now described as Antenatal Service, to more appropriately describe the activity undertaken for item 16400. Notes T4.1.6 and T4.1.7 have been amended accordingly.
- **General Surgery - N**ew item, 30062, has been included to provide for the service of removing an Etonogestral (Implanon®) subcutaneous implant. Explanatory note T8.24.12, applying to items 31300-31335 has been amended to clarify the definition of definitive excision.
- **Note T8.7.8 -** this note has been reinstated in to the MBS as it was inadvertently removed from the 1 November 2006 MBS.
- **High Dose Rate Brachytherapy -** Item 37227 has been amended to replace associated items 15327 and 15328 with the more appropriate items, 15331 and 15332. Note T8.59 has been amended to clarify that if the service is performed by an urologist, a radiation oncologist must be present in person at the time of the service.
- **Cardio-Thoracic Surgery -** Items 38200, 38203 and 38206 were amended to clarify that not every service listed in the item descriptor needs to be performed in order to claim those items.
- **Plastic and Reconstructive Surgery -** Items 45564 and 45565 were amended to clarify that the items cover up to 2 microvascular anastomoses. New item 45561 has been introduced to provide for microvascular anastomosis for the purpose of supercharging pedicled flaps.
- **Mental Health -** The requirements for items 80000 to 80170 under the *Better Access to Psychiatrists, Psychologists, and General Practitioners through the Medicare Benefits Schedule* initiative have been amended to make clear that specialist psychiatrists and paediatricians can directly refer to allied mental health professionals where an eligible specialist service (MBS items 104 to 109) has been provided to a patient with an assessed mental disorder. Revisions have also been made to clarify that a course of treatment involves a maximum of six allied mental health services and that allied mental health professionals are expected to provide a written report back to the referring medical practitioner after completion of each course of treatment.
- **Allied Health –** From 1 May 2007, new items (81100 to 81125) have been introduced to provide Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

A.15 Referred Patient Assessment and Management Plan (Items 291 to 293), Initial Consultations for NEW PATIENTS (Items 296 to 299) and Referral to Allied Health Professionals (for new and continuing patients)

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

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

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

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

A.15.4 It is expected that item 291 will be a single attendance. However, there may be particular circumstances where a medical practitioner practising in general practice has referred a patient for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, items 296, 297 or 299 (for a new patient) or 300-308 (for continuing patients) may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring medical practitioner with an assessment and management plan. It is not intended that items 296, 297, 299 or 300-308 will generally or routinely be used in conjunction with, or prior to, item 291.

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

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

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

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

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

History and Examination

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

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

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

Diagnosis

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

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

Psychiatric formulation

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

Management plan

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

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

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

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

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

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

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

Initial Consultation for a NEW PATIENT (item 296 in rooms, item 297 at hospital, and item 299 for home visits)

A.15.6 The rationale for items 296 - 299 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for items 296 - 299 may be from a medical practitioner practising in general practice, a specialist or another consultant physician.

A.15.7 It is intended that either item 296, 297 or 299 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist, **unless** the patient is referred by a medical practitioner practising in general practice for an assessment and management plan, in which case the consultant psychiatrist, if he or she agrees that the patient is suitable for management in a general practice setting, will use item 291 where an assessment and management plan is provided to the referring practitioner.

A.15.8 There may be particular circumstances where a medical practitioner practising in general practice has referred a patient to a consultant psychiatrist for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, item 296, 297 or 299 (for a new patient) or 300-308 (for continuing patients) may be used and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) and provides the referring medical practitioner with an assessment and management plan. It is not generally intended that item 296, 297 or 299 will be used in conjunction with, or prior to, item 291.

A.15.9 Use of items 296 - 299 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

A.15.10 Items 300 - 308 are available for consultations in consulting rooms other than those provided under item 296, and items 291 - 293. Similarly time tiered items remain available for hospital and home visits. These would cover a new course of attention for patients who have already been seen by the consultant psychiatrist in the preceding 24 months as well as subsequent consultations for all patients.

Referral to Allied Mental Health Professionals (for new and continuing patients)

A.15.11 To increase the clinical treatment options available to psychiatrists and paediatricians for which a Medicare benefit is payable, patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items) may be referred to an allied mental health professional for a total of twelve individual allied mental health services in a calendar year. The twelve services may consist of: psychological therapy services (items 80000 to 80015) - provided by eligible clinical psychologists; and/or focussed psychological strategies - allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165) - provided by eligible psychologists, occupational therapists and social workers. These services should be provided, as required, in up to two groups of six sessions with the need for the second group of sessions to be reviewed by the referring practitioner after the initial six sessions.

A.15.12 While such referrals are likely to occur for new patients seen under items 296 - 299, they are also available for patients at any point in treatment, as clinically required, under the same arrangements and limitations as outlined in A.15.11. There is provision for a further referral for up to an additional six individual services to be provided in exceptional circumstances. Exceptional circumstances apply where there has been a significant change in the patient's clinical condition or care circumstances which requires further allied mental health services. In such cases, the patient's referral should be annotated to briefly indicate the reason why the additional services were required in excess of the twelve individual services permitted within a calendar year. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

A.15.13 Patients will also be eligible to claim up to twelve services within a calendar year for group psychotherapy with 6-10 patients to which items 80020 (psychological therapy - clinical psychologist), 80120 (focussed psychological strategies - psychologist), 80145 (focussed psychological strategies - occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 services per calendar year maximum associated with those items.

A.22 CHRONIC DISEASE MANAGEMENT ITEMS (Items 721 to 731)

A.22.10 For patients to be eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive) they must have both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare. However, residents of aged care facilities are eligible to access rebates under the allied health and dental care items where their GP has contributed to a care plan prepared for them (Item 731) and the contribution item has been claimed on Medicare. In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

ADDITIONAL INFORMATION

A.22.41 Before proceeding with any EPC CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer;

(b) in the case of TCA and TCA review services, any likely out-of-pocket costs to the patient for the involvement of other providers are explained to the patient; and

(c) the patient's agreement to proceed is recorded.

Note that Medicare rebates are only payable for certain allied health and dental services, provided to the patient on referral from the patient's GP, after both a GPMP and TCA are in place and claimed on Medicare or after item 731 (for aged care residents) is in place and claimed on Medicare. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of TCAs, multidisciplinary care plans, TCA reviews or multidisciplinary care plan reviews.

In addition, patients with type 2 diabetes may also access new MBS items 81100, 81105, 81110, 81115, 81120, 81125 (Allied Health Group Services for Patients with Type 2 Diabetes) subject to patient eligibility and other restrictions.

A.32 GP Mental Health Care Items

A.32.17 Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Care Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Care Plan Review item. A rebate for preparation of a GP Mental Health Care Plan will not be paid within 12 months of a previous claim for the patient for the same item or within 12 months of a claim for a 3 Step Mental Health Process (former items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) or within three months following a claim for a review (item 2712), other than in exceptional circumstances.

A.33 Provision of Focussed Psychological Strategies (Items 2721 - 2727)

A.33.1 Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a 3 Step Mental Health Process (former items 2574, 2575, 2577, 2578 and 2704, 2705, 2707 and 2708), a GP Mental Health Care Plan or a Psychiatrist Assessment and Management Plan.

A.35 Telepsychiatry

A.35.1 **Telepsychiatry** is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

A.35.2 **Education and Training**

Consultant Psychiatrists must have completed the *online Telepsychiatry Certification Module* available on the Royal Australian and New Zealand College of Psychiatrists (RANZCP) website. The RANZCP will keep a register of those consultant psychiatrists who have completed the *online Telepsychiatry Certification Module* and make it available to Medicare Australia for auditing purposes.

A.35.3 **Duration of Telepsychiatry Consultation**

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

A.35.4 **Number of Consultations in a Calendar Year**

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. Items 364 to 370 are to be claimed where face-to-face consultations are clinically indicated. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.

If the number of attendances in aggregate to which items 300 to 308 and items 353 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

A.35.5 **Documenting the Telepsychiatry Session**

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring medical practitioner after the first session and then, at a minimum, after every six consultations.

A.35.6 **Geographical**

Telepsychiatry items 353 to 358 are available for use when a referred patient is located in a regional, rural or remote area. A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

T1.4 Assisted Reproductive Services (Items 13200 - 13251)

T1.4.1 With the exception of items 37605 and 37606, Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology) in lieu of or in conjunction with Items 13200 - 13221. Specifically, Medicare benefits are not payable for Items 13200 - 13221 in association with Item 104, 105, 14203, 14206, 35637, 66695 - 66716 or 73521 - 73529. Items 14203 and 14206 are not payable for artificial insemination.

T1.4.2 A treatment cycle is a series of treatment for the purposes of in vitro fertilisation (IVF), gamete intrafallopian transfer (GIFT) or similar procedures and is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.

T1.4.3 The date of service in respect of treatment covered by Items 13200, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle, except in the case of Item 13218 where the service is provided to a patient in hospital. In this case, the account should separately identify the actual date of the service.

T1.4.4 For treatment covered by Items 13200, 13203, 13206 and 13218 the account must be provided by the gynaecologist supervising the treatment cycle.

T1.4.5 Embryology laboratory services covered by Items 13200 and 13206 include egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing. It does not include semen preparation.

T1.4.6 Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

T1.4.7 Items 13200, 13206, 13215 and 13218, 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

T1.4.8 Items 13200 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify Medicare Australia of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these two items.

T1.4.9 Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies.

Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

T4.1 Antenatal service provided by a nurse, midwife or a registered Aboriginal Health Worker (Item 16400)

T4.1.6 A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

T4.1.7 A registered Aboriginal Health Worker means an Aboriginal Health Worker who holds current registration issued by a State or Territory regulatory authority; and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. This includes a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*. The Aboriginal Health Worker must have appropriate training and skills to provide an antenatal service.

T8.7.8 Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and a cosmetic or other non-rebatable services are discussed, this would be considered a rebatable service under Medicare;

Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare; and

Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

T8.24 Removal of Skin Lesions

T8.24.12 Definitive surgical excision for items 31300 to 31335 is defined as "surgical removal with an adequate margin and, as a result, no further surgery is indicated at that site of excision.

T8.59 High Dose Rate Brachytherapy (Item 37227)

T8.59.1 Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

T8.61 Transcutaneous Sperm Retrieval (Item 37605)

T8.61.1 Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

T8.61.2 Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

T8.61.3 Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

T 8.62 Surgical sperm retrieval, by open approach (Item 37606)

T8.62.1 Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

T8.62.2 Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

T8.62.3 Benefit is not payable for item 37606 in conjunction with item 37604.

M.6.5 ADDITIONAL REQUIREMENTS OF THE PSYCHOLOGICAL THERAPY SERVICES

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies ─ such as interpersonal therapy ─ may be used if considered clinically relevant.

Reporting back to the referring medical practitioner
Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.7.5 ADDITIONAL REQUIREMENTS OF THE FOCUSSED PSYCHOLOGICAL STRATEGIES SERVICES

Service length and type
Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied health professionals utilising the FPS items. These are:

1. **Psycho-education**
   (including motivational interviewing)
2. **Cognitive-behavioural Therapy including:**
   - **Behavioural interventions**
     - Behaviour modification
     - Exposure techniques
     - Activity scheduling
   - **Cognitive interventions**
     - Cognitive therapy
3. **Relaxation strategies**
   - Progressive muscle relaxation
   - Controlled breathing
4. **Skills training**
   - Problem solving skills and training
   - Anger management

- Social skills training
- Communication training
- Stress management
- Parent management training

5. **Interpersonal Therapy** (especially for depression)

There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.

Reporting back to the referring medical practitioner
Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline. A copy of the Medicare Allied Health and Dental Care Supplement can be accessed from this site. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.9 ALLIED HEALTH GROUP SERVICES (ITEMS 81100 TO 81125)

M.9.1 OVERVIEW

In May 2007, new MBS items (81100 to 81125) will be introduced for allied health group services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

Services available under these new items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970 in explanatory note M.3).

General information about the Australian Medicare program and claiming from Medicare Australia is provided in Section 1 of the Medicare Benefits Schedule Allied Health and Dental Services Supplement (effective 1 November 2006). This supplement is available on the Department of Health and Ageing website at www.health.gov.au/mbsonline.

To access the new group items the patient must:

- have type 2 diabetes; and
- have an appropriate care plan in place, as outlined at M.9.2 below; and
- be referred by his/her GP to an eligible diabetes educator, exercise physiologist or dietitian using a referral form.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120). A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

It is important to note that:

- before a Medicare rebate can be paid for the allied health assessment item (items 81100, 81110 or 81120) either the patient or the GP must have lodged a claim with Medicare Australia for the relevant GP care planning item and received payment for that claim; and
- before a Medicare rebate can be paid for the allied health group items (81105, 81115 and 81125) either the patient or the allied health professional must have lodged a claim with Medicare Australia for the assessment item and received payment for that claim.

M.9.2 PATIENT ELIGIBILITY AND GP REFERRAL REQUIREMENTS

Eligible Patients

Items 81100 to 81125 only apply to patients with type 2 diabetes. To be eligible for these services, the patient must have in place one of the following:

- a GP Management Plan (GPMP) – item 721; or
- where a patient has an existing GP Management Plan, the GP has reviewed that plan (item 725); or
- for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for allied health group services under these items, as the self management approach offered in group services may not be appropriate.]
-

Unlike the existing individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (item 723) in order for the patient to be referred for allied health group services.

Referral requirements

The patient must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment, preparing him/her for an appropriate group services program (under item 81100, 81110 or 81120).

When referring patients, GPs need to use the *Referral form for allied health group services under Medicare*, provided by the Commonwealth Department of Health and Ageing. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. The form can be modified to suit practice needs (for example, relevant software packages) as long as the information is substantially retained.

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

M.9.3 ELIGIBLE ALLIED HEALTH PROFESSIONALS

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia. If providers are already registered with Medicare Australia to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

Diabetes Educator: must be a 'Credentialled Diabetes Educator' (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

Exercise Physiologists: must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).

Dietitian: must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Medicare Australia registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

M.9.4 ASSESSMENT FOR GROUP SERVICES (ITEMS 81100, 81110 AND 81120)

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (item 81120), on referral from a GP. The purpose of this service is to undertake an individual assessment of the patient and preparing him/her for an appropriate group services program. It involves taking a comprehensive patient history, identification of individual goals and preparing the patient for the group service. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year
Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.
If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact Medicare Australia to confirm whether the appropriate care planning item is in place and/or the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Referral Form
The GP must refer the patient using the *Referral form for allied health group services under Medicare.* The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Length of service
This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Rebate
The Medicare rebate for the assessment items is $60.00.

Reporting Requirements
On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

M.9.5 GROUP SERVICES (ITEMS 81105, 81115 AND 81125)

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year
Patients are eligible for up to eight (8) allied health group services in total (81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. either a diabetes educator, exercise physiologist or dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (eg 8 diabetes education services) or a combination of services (eg 3 diabetes education services, 3 dietitian services and 2 exercise physiology services). An eligible allied health professional with more than one Medicare provider number (eg for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Allied health group service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of 8 group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.
If there is any doubt about a patient's eligibility for group services, the allied health professional should contact Medicare Australia to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Multiple Services on the Same Day
Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral Form
The allied health professional/s undertaking the group services will need to receive the *Referral form for allied health group services under Medicare*, for which Part B has been completed by the provider who has undertaken the assessment service.

Group Size
The service must be provided to a person who is part of a group of between 2 and 12 persons.

Length of service
Each group service must be of at least 60 minutes duration.

Rebate
The Medicare rebate for items 81105, 81115 and 81125 is $15.00 for each patient. For example, if there are 10 patients in a group, a total of $150 can be claimed in Medicare benefits.

Reporting Requirements
On completion of the group services program, each allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved. While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the patient, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

M.9.6 ADDITIONAL REQUIREMENTS

Retention of Referral Form for Medicare Australia Audit Purposes
Allied health professionals are required to retain a copy of the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

Publicly funded services
Items 81100 – 81125 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 81100-81125 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be bulk billed.

Private Health Insurance
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid.

Out-of-pocket expenses and Medicare Safety Net
Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out of pocket costs will count toward the Medicare Safety Net for that patient.

M.9.7 FURTHER INFORMATION

Further information about these items is available on the Department of Health and Ageing's website at www.health.gov.au/epc.

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

- Nuclear Medicine Item 61462 (repeat planar) has been amended to achieve seamless Medicare Australia claims processing by removing the derived fee and including a separately calculated fee.
- New item 61505 has been introduced to reimburse a CT performed attenuation correction (AC) and anatomical localisation (AL) in conjunction with a single photon emission tomography (this is often referred to as Single Photon Emission Computed Tomography, SPECT).

CHANGES TO THE MEDICARE BENEFITS SCHEDULE
EFFECTIVE - 1 MARCH 2007

On **1 March 2007**, a number of minor changes have been made to the emergency after-hours MBS items for GP's (items 1, 2, 601 & 602) Other Medical Practitioners (items 97, 98, 697 & 698) and sports physicians (items 448 & 449) including

- replacing the term "emergency" with the term "urgent";
- allowing requests for urgent attendances, including surgery consultations, to be taken up to two hours prior to commencement of an after-hours period; and
- allowing regular providers of after-hours services to use the urgent after-hours home visit items.

These changes will provide greater flexibility for after-hours service providers and clarify the conditions under which the items may be claimed.

These 1 March 2007 amendments can be viewed here at the Publications Page.

CHANGES TO THE MEDICARE BENEFITS SCHEDULE
EFFECTIVE - 1 APRIL 2007

The following changes have been introduced in the MBS with effect from **1 April 2007** and can be viewed here at the Publications Page.

- Attendance Note A.5 (outlined below) has been amended to reflect a change to the definition of a General Practitioner.
- General Explanatory Note 4 has also been amended and can be viewed along with the complete set of General Explanatory Notes at the link above.
- A new item number 12323 has been introduced to provide a service for testing persons over the age of 70 years for the measurement of bone mineral density. Explanatory Note D1.26 accompanies this new item.

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

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

- listed on the Vocational Register of General Practitioners maintained by Medicare Australia;
- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or
- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program.
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

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

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

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

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

LEVEL A

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

Example: Triple Antigen or Tetanus Immunisation

LEVEL B

The descriptions of these items introduce the words 'selective history' and 'implementation of a management plan in relation to one or more problems'. In this context a 'selective history' means a history relating to a specific problem or condition; and 'implementation of a management plan' includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering

tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels A and B relate not to time but to complexity.
Example: Otitis media presenting as earache

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

LEVEL D
These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.
Examples: Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Counselling or Advice to Patients or Relatives
A.5.5 For items 23 to 51 and 5020 to 5067 'implementation of a management plan' includes counselling services.
A.5.6 Items 1 to 51 and 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.
A.5.7 For items 5906 to 5912 'implementation of a management plan' includes counselling services.
A.5.8 Items 5906 to 5912 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes
A.5.9 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance
A.5.10 Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes.

After-Hours Attendances (Items 5000 - 5067 and 5200 - 5267)
A.5.11 There are attendance items (5000 - 5067 and 5200 - 5267) for medical services that are rendered after-hours. These items apply to GP and other non-referred attendances provided after-hours in a consulting room, residential aged care facility, institution or home.
A.5.12 An after-hours attendance or visit is a reference to a consultation provided on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a weekday not being a public holiday. In order to claim items 5000 - 5067 and 5200 - 5267, the professional attendance itself must begin in an after-hours period regardless of when the appointment was made.
A.5.13 Where a practice or clinic routinely conducts surgery consultations during an after-hours period, the medical practitioner would only use the standard after-hours attendance items (items 5000 - 5067 and 5200 - 5267) and not the items for urgent after-hours attendances at consulting rooms (items 2, 98, 448, 449, 602, 698).
A.5.14 Paragraph A.10 of the explanatory notes provides additional information regarding the items for urgent after-hours attendances (1, 2, 97, 98, 448, 449, 601, 602, 697, 698).

D1.26 Bone Densitometry (Items 12306 to 12323)

D1.26.1 Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

D1.26.2 The addition of item 12323 from 1 April 2007 will enable the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. The Government has decided to expand access to Medicare subsidised bone mineral density testing to coincide with the expanded eligibility for the osteoporosis medication 'alendronate' under the Pharmaceutical Benefits Scheme.

D1.26.3 An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at both forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals

D1.26.4 Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12309, 12312, 12315, 12318 and 12321.

D1.26.5 For Items 12306 and 12309 the referral should specify the indication for the test, namely:

(a) 1 or more fractures occurring after minimal trauma; or
(b) monitoring of low bone mineral density proven by previous bone densitometry.

D1.26.6 For Item 12312 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism; or
(d) female hypogonadism lasting more than 6 months before the age of 45.

D1.26.7 For Item 12315 the referral should specify the indication for the test, namely:

(a) primary hyperparathyroidism;
(b) chronic liver disease;
(c) chronic renal disease;
(d) proven malabsorptive disorders;
(e) rheumatoid arthritis; or
(f) conditions associated with thyroxine excess.

D1.26.8 For Item 12318 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism;
(d) female hypogonadism lasting more than 6 months before the age of 45;
(e) primary hyperparathyroidism;
(f) chronic liver disease;
(g) chronic renal disease;
(h) proven malabsorptive disorders;
(i) rheumatoid arthritis; or
(j) conditions associated with thyroxine excess.

Definitions

D1.26.9 Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

D1.26.10 For Items 12312 and 12318

(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or

(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;

for a period anticipated to last for at least 4 months.

Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

D1.26.11 For Items 12312 and 12318

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.

(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

D1.26.12 For Items 12315 and 12318

A malabsorptive disorder is defined as one or more of the following:

(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or

(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or

(c) histologically proven Coeliac disease.

DIAGNOSTIC	**OTHER**
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
Effective 1 April 2007 12323	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy **X ray absorptiometry or quantitative computerised tomography**, for the measurement of bone mineral density, for a person aged 70 years or over. Measurement of 2 or more sites including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315, 12318 or 12321 applies. (Ministerial Determination). *(See para D1.26 of explanatory notes to this Category)* **Fee:** $90.45 **Benefit:** 75% = $67.85 85% = $76.90

SUMMARY OF CHANGES

The 1 May 2007 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

13251 30062 37605 37606 45561 61505 81100 81105 81110 81115 81120 81125

Deleted Items

2574 2575 2577 2578 2704 2705 2707 2708

Amended Description

353 364 2710 2721 31300 37227 38200 38203 38206 45564 45565 80000 80010 80020 80100 80110 80120 80125 80135 80145 80150 80160 80170

Fee Amended

299 353 355 356 357 358 367 369 61462

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 2007 and continues beyond that date, the old (1 November 2006) 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 2007

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, 717
Group A15 *(all items other than items 746, 749, 757, 768, 771, 773, 820-866)*	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,
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
Group A20	GP mental health care	2710, 2712, 2713, 2721, 2723, 2725, 2727
Group A27	Pregnancy support counselling	4001
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 M5	Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner	10988, 10989
Group M2	Services provided by a practice nurse on behalf of a medical practitioner	10993, 10994, 10995, 10996, 10998, 10999

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

CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, HOME VISITS

Professional attendance of more than 45 minutes at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a medical practitioner, and where the patient:

- is a new patient for this consultant psychiatrist; or
- is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months.

Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 297, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period

\+ *(See para A.15 of explanatory notes to this Category)*

299 **Fee:** $275.10 **Benefit:** 75% = $206.35 85% = $233.85

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR ASSESSMENT, DIAGNOSIS AND TREATMENT

A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of PSYCHIATRY (not being an attendance to which items 291 to 319 apply), where:

-the patient is referred to him or her by a medical practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (RRMA3-7),

-that consultation and any other consultation to which items 353 to 358 apply, have not exceeded 12 consultations in a calendar year,

-any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year.

‡ A telepsychiatry consultation of not more than 15 minutes duration.

\+ *(See para A.39 of explanatory notes to this Category)*

353 **Fee:** $50.60 **Benefit:** 75% = $37.95 85% = $43.05

A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration.

\+ *(See para A.39 of explanatory notes to this Category)*

355 **Fee:** $101.10 **Benefit:** 75% = $75.85 85% = $85.95

A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration.

\+ *(See para A.39 of explanatory notes to this Category)*

356 **Fee:** $148.25 **Benefit:** 75% = $111.20 85% = $126.05

A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration

\+ *(See para A.39 of explanatory notes to this Category)*

357 **Fee:** $204.55 **Benefit:** 75% = $153.45 85% = $173.90

A telepsychiatry consultation of more than 75 minutes duration

\+ *(See para A.39 of explanatory notes to this Category)*

358 **Fee:** $249.15 **Benefit:** 75% = $186.90 85% = $211.80

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY

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,
- that attendance occurs following a telepsychiatry consultation (items 353 to 358),
- that attendance and any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year.

These items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 358.

A face-to-face attendance of not more than 15 minutes duration.

‡ *(See para A.39 of explanatory notes to this Category)*

364 **Fee:** $38.30 **Benefit:** 75% = $28.75 85% = $32.60

A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration.

\+ *(See para A.39 of explanatory notes to this Category)*

367 **Fee:** $117.60 **Benefit:** 75% = $88.20 85% = $100.00

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST
+ 369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration *(See para A.39 of explanatory notes to this Category)* **Fee:** $162.40 **Benefit:** 75% = $121.80 85% = $138.05	
MEDICAL PRACTITIONER		**MEDICAL PRACTITIONER**
	GROUP A20 - GP MENTAL HEALTH CARE	
	SUBGROUP 1 - GP MENTAL HEALTH CARE PLANS	
‡ 2710	**PREPARATION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) of a **GP MENTAL HEALTH CARE PLAN** for a patient (not being a service associated with a service to which **items 2713 or 734 to 779** apply). A rebate will not be paid within twelve months of a previous claim for the same item, within twelve months of a claim for a former 3 Step Mental Health Process (items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Care Plan. *(See para A.36 of explanatory notes to this Category)* **Fee:** $150.00 **Benefit:** 75% = $112.50 100% = $150.00	
	SUBGROUP 2 - FOCUSSED PSYCHOLOGICAL STRATEGIES	
‡ 2721	**MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES** **Note: These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.** Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialled medical practitioner and are time limited; being deliverable, in general, in up to 12 planned sessions comprising two groups of up to six sessions. In exceptional circumstances, following review by the practitioner managing either the former 3 Step Mental Health Process, the GP Mental Health Care Plan or the Psychiatric Assessment and Management Plan, up to a further 6 sessions may be approved in a calendar year to an individual patient. Medical practitioners must be notified to Medicare Australia by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills. A session should last for a minimum of 30 minutes. **FPS ATTENDANCE** Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental disorders by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.37 of explanatory notes to this Category)* **Fee:** $80.35 **Benefit:** 100% = $80.35	
MISCELLANEOUS		**ASSISTED REPRODUCTIVE SERVICES**
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES	
	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES	
† 13251	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13218 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $380.00 **Benefit:** 75% = $285.00 85% = $323.00	

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

†
30062 Etonogestral subcutaneous implant, removal of, as an independant procedure (Anaes.)
Fee: $53.65 **Benefit:** 75% = $40.25 85% = $45.65

TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS

Definitive surgical excision for items 31300-31335 is defined as "surgical removal with an adequate margin and as a result, no further surgery is indicated at that site of excision".

‡
31300 MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***
(Anaes.)
(See para T8.25 of explanatory notes to this Category)
Fee: $282.70 **Benefit:** 75% = $212.05 85% = $240.30

SUBGROUP 5 - UROLOGICAL

‡
37227 PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.)
(See para T8.59 of explanatory notes to this Category)
Fee: $500.00 **Benefit:** 75% = $375.00 85% = $436.10

†
37605 TRANSCUTANEOUS SPERM RETRIEVAL, unilateral, from either the testis or the epididymis, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, excluding a service to which item 13218 applies (Anaes.)
(See para T8.61 of explanatory notes to this Category)
Fee: $330.00 Benefit: 75% = $247.50 85% = $280.50

†
37606 OPEN SURGICAL SPERM RETRIEVAL, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, performed in a hospital or approved day hospital facility, excluding a service to which item 13218 or 37604 applies (Anaes.)
(See para T8.62 of explanatory notes to this Category)
Fee: $490.00 Benefit: 75% = $367.50 85% = $426.10

SUBGROUP 6 - CARDIO-THORACIC

CARDIOLOGY PROCEDURES

‡
38200 RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test
(Anaes.)
Fee: $393.60 **Benefit:** 75% = $295.20 85% = $334.60

‡
38203 LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test
(Anaes.)
Fee: $469.65 **Benefit:** 75% = $352.25 85% = $405.75

‡
38206 RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test
(Anaes.)
Fee: $567.85 **Benefit:** 75% = $425.90 85% = $503.95

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY

† 45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.) **Fee:** $1,568.20 **Benefit:** 75% = $1,176.15
‡ 45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) **Fee:** $2,250.00 **Benefit:** 75% = $1,687.50
‡ 45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) **Fee:** $1,687.55 **Benefit:** 75% = $1,265.70

GROUP I4 - NUCLEAR MEDICINE IMAGING

+ 61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453 or 61469, where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) **Fee:** $129.00 **Benefit:** 75% = $96.75 85% = $109.65
† 61505	CT scan performed at the same time and covering the same body area as SPECT for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 – 61650 (R) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES

‡ 80000	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. (Professional attendance at consulting rooms) *(See para M.6 of explanatory notes to this Category)* **Fee:** $88.20 **Benefit:** 85% = $75.00
‡ 80010	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. (Professional attendance at consulting rooms) *(See para M.6 of explanatory notes to this Category)* **Fee:** $129.40 **Benefit:** 85% = $110.00
‡ 80020	Professional attendance for the purpose of providing psychological therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply). - GROUP PSYCHOTHERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.6 of explanatory notes to this Category)* **Fee:** $32.90 **Benefit:** 85% = $28.00

GROUP M7 - FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)

‡ 80100

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.

(See para M.7 of explanatory notes to this Category)

Fee: $62.50 **Benefit:** 85% = $53.15

‡ 80110

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.

(See para M.7 of explanatory notes to this Category)

Fee: $88.20 **Benefit:** 85% = $75.00

‡ 80120

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply).

GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT

(See para M.7 of explanatory notes to this Category)

Fee: $22.45 **Benefit:** 85% = $19.10

‡ 80125

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.

(See para M.7 of explanatory notes to this Category)

Fee: $55.05 **Benefit:** 85% = $46.80

‡ 80135	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.70 **Benefit:** 85% = $66.05
‡ 80145	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.7 of explanatory notes to this Category)* **Fee:** $19.75 **Benefit:** 85% = $16.80
‡ 80150	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
‡ 80160	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.70 **Benefit:** 85% = $66.05

	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply*).* GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT
‡ 80170	*(See para M.7 of explanatory notes to this Category)* **Fee:** $19.75 **Benefit:** 85% = $16.80

GROUP M9 - ALLIED HEALTH GROUP SERVICES

DIABETES EDUCATION SERVICE – ASSESSMENT FOR GROUP SERVICES

Diabetes education health service provided to a person by an eligible diabetes educator for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and
(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
(c) the person is referred to an eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that substantially complies with the form issued by the Department; and
(d) the person is not an admitted patient of a hospital; and
(e) the service is provided to the person individually and in person; and
(f) the service is of at least 45 minutes duration; and
(g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

† 81100 *(See para M.9 of explanatory notes to this Category)*
Fee: $70.55 **Benefit:** 85% = $60.00

DIABETES EDUCATION SERVICE – GROUP SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if:

(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
(b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is provided to a person involving the personal attendance by an eligible diabetes educator; and
(e) the service is of at least 60 minutes duration; and
(f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible diabetes educator prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
(g) an attendance record for the group is maintained by the eligible diabetes educator; and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

† 81105 *(See para M.9 of explanatory notes to this Category)*
Fee: $17.60 **Benefit:** 85% = $15.00

EXERCISE PHYSIOLOGY SERVICE – ASSESSMENT FOR GROUP SERVICES

Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and
(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
(c) the person is referred to an eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that substantially complies with the form issued by the Department; and
(d) the person is not an admitted patient of a hospital; and
(e) the service is provided to the person individually and in person; and
(f) the service is of at least 45 minutes duration; and
(g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

† *(See para M.9 of explanatory notes to this Category)*

81110 **Fee:** $70.55 **Benefit:** 85% = $60.00

EXERCISE PHYSIOLOGY SERVICE – GROUP SERVICE

Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if:

(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 8100, 81110 or 81120; and
(b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and
(e) the service is of at least 60 minutes duration; and
(f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
(g) an attendance record for the group is maintained by the eligible exercise physiologist; and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

† *(See para M.9 of explanatory notes to this Category)*

81115 **Fee:** $17.60 **Benefit:** 85% = $15.00

DIETETICS SERVICE – ASSESSMENT FOR GROUP SERVICES

Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and
(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
(c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that substantially complies with the form issued by the Department; and
(d) the person is not an admitted patient of a hospital; and
(e) the service is provided to the person individually and in person; and
(f) the service is of at least 45 minutes duration; and
(g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and item 81120 apply).

† *(See para M.9 of explanatory notes to this Category)*

81120 **Fee:** $70.55 **Benefit:** 85% = $60.00

DIETETICS SERVICE – GROUP SERVICE

Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if:

(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
(b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is provided to a person involving the personal attendance by an eligible dietitian; and
(e) the service is of at least 60 minutes duration; and
(f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietitian prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
(g) an attendance record for the group is maintained by the eligible dietitian; and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

† *(See para M.9 of explanatory notes to this Category)*

81125 **Fee:** $17.60 **Benefit:** 85% = $15.00