The Australian Government
Department of Health and Ageing

Supplement to the

Medicare Benefits Schedule

Of 1 November 2007

Effective 1 July 2008

Medicare Benefits Schedule Supplement - effective 1 July 2008

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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 2007 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 JULY 2008

This supplement provides details of changes to the 1 November 2007 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2007 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 $365.70 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 2008.

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 $529.30 for registered families in receipt of Family Tax Benefit (A) and concession card holders, or $1,058.70 for all other individuals and families is reached. These thresholds were increased with effect from 1 January 2008.

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 2008. 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.

REVIEW OF GENERAL MEDICAL SERVICES

- **Autism or any other Pervasive Developmental Disorder** - Two new items have been introduced as part of the *Helping Children with Autism* package for paediatricians and psychiatrists for diagnosis and management of autism or any other pervasive developmental disorder. Explanatory note A.13 has been added to clarify the requirements, appropriate use of and referral to Allied Health Professional services under items 135 and 289.
  New MBS items (82000 to 82025, inclusive) have also been introduced for services provided by Allied Health Professionals to children (under 13 years for diagnosis, and under 15 years for treatment) who have or are suspected of having a pervasive developmental disorder. New associated Note M10 is outlined below.
- **Healthy Kids Check** - Items 709 and 711 have been introduced to support general practitioners and practice nurses to undertake a health check for a patient who is receiving or has received their four year old immunisation.
- **Type 2 Diabetes Risk Evaluation** - Item 713 forms part of the 'COAG - reducing the risk of type 2 diabetes' initiative to address the significant growth in type 2 diabetes in Australia. This item enables GPs to preview patients 40 to 49 years of age who are at high risk of developing type 2 diabetes and instigate early interventions to assist in the prevention of type 2 diabetes.
- **Radiation Oncology** - Four new items have been introduced in the radiation oncology section (Group T2) of the schedule covering treatment verification procedures and radiation source localisation for high dose brachytherapy. The new items are 15700, 15705, 15800 and 15850.

Currently, radiation oncologists use the most relevant diagnostic imaging item for treatment verification procedures and radiation source localisation for high dose brachytherapy. The diagnostic imaging items should no longer be used for these procedures. The new items more appropriately describe the services being provided by radiation oncologists. New Notes T2.5 and T2.6 (outlined below) have also been introduced describing these new items in more detail.
The items have been introduced through a determination made under section 3C of the Act, pending permanent inclusion in the General Medical Services Table.

- **Therapeutic Nuclear Medicine -** Item 16018 has been amended to allow all cancer patients (not only those with carcinoma of the prostate and breast) to access this radioisotope treatment for the relief of bone pain caused from secondary bony metastases where other forms of treatment have failed.
- **Regional or Field Nerve Blocks -** Item 18292 has been amended to allow claiming in association with items 18354, 18356 and 18358. This change will assist children with cerebral palsy to access Medicare benefits where an injection of a neurolytic agent is also required as part of their treatment with Botulinum Toxin.
- **Anaesthesia - Relative Value Guide**
  - New anaesthesia items 20147, 20230, 20355, 20475, 20704, 20863, 20905, 20911, 20920, 21155, 21275, 21445, 21535, 21685, 21785, 21865 and 21981 have been introduced to improve the structure of the RVG which is generally organised in a logical and clinically relevant manner utilising anatomical regions.
  - Item 20920 has been amended in keeping with the clear pattern of a higher allocation of RVG base units for anaesthesia for surgery on deeper structures reflecting the greater complexity of anaesthesia required.
  - Item 20942 has been amended to reflect a range of newer similar surgical procedures as the previous terms of colpotomy, colpectomy and colporraphy are now not in frequent medical usage.
  - Item 22007 has been amended to allow the item to apply where the patient is either conscious or anaesthetised.
  - New Explanatory Notes T10.28, T10.29 and T10.30 outline the restrictions on benefits payable for items 20230, 20355, 20475, 20704, 20905, 20911, 21155, 21275, 21455, 21535, 21685, 21785, 21865, and 21981.
- **Reversal of Sterilisation procedures -** Benefits have been reinstated under Items 35700, 37616, 37619 and 59736 for reversal of sterilisation procedures in order to restore fertility.
- **Orthopaedic -** Items 49503 and 49506 have been amended to clarify the requirements of the items.
- **Bowel Surgery -** A minor amendment has been made to item 30487 to clarify that it should be provided as an independent procedure.
- **Ophthalmology -** Explanatory note T8.82 has been amended to clarify the equipment required in order to remove a foreign body and rust rings under item 42644. A new item 42741 has been introduced for posterior juxtascleral depot injections.
- **Pain pumps for post-operative pain management -** General explanatory note 13.5 (described below) has been introduced to clarify that the cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.
- **Psychological Therapy Services and Focussed Psychological Strategies** have had a minor amendment made to their Notes M6 and M7 (outlined below) to reflect the correct item number range for referral purposes. ie. 110 to 133.
- **Discontinuation of Medicare Dental Items 85011-87777** - The Medicare dental items for people with chronic conditions and complex care needs have been withdrawn from the MBS effective 1 July 2008. No Medicare benefits will be payable for dental services provided after 30 June 2008. For further information please visit Discontinuation of Medicare Dental Items 85011-87777

13.5 Pain pumps for post-operative pain management

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

A.13 Referred patient assessment, diagnosis and treatment and management plan for autism or any other pervasive developmental disorder (items 135 and 289)

Items 135 or 289 are available on referral from a medical practitioner for consultant paediatricians or psychiatrists to provide early diagnosis and treatment of autism or any other pervasive development disorders (PDD) for children aged under 13 years. Both items include assessment, diagnosis and the creation of a treatment and management plan. The treating practitioner can access assistance from allied health professionals (psychologists, occupational therapists and speech pathologists), where appropriate, to collaborate in both the diagnosis and treatment of autism or any other pervasive developmental disorder. Items 135 or 289 are claimable only once per patient per lifetime, where there is no existing claim for a PDD treatment and management plan.

The diagnosis, assessment and treatment and management plan should be explained, discussed and a copy of the plan provided to the patient and their family and/or carer(s).

Where the patient presents with another morbidity in addition to PDD, item 132 can be used. However, the use of this item will not provide access to assistance with assessment, diagnosis and treatment from allied health professionals (AHP).

Items 135 or 289 also provide a referral pathway for access to services provided through Autism Advisory Services by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). For further information on assistance available through FaHCSIA, phone 1800 289 177, or on TTY 1800 260 402.

Referred Patient Treatment and Management Plan Guidelines
It is advisable before using item 135 or 289 that practitioners familiarise themselves with the "*Guidelines for the assessment of autistic spectrum disorders in Australia*". Practitioners can access these guidelines online at: http://www.med.monash.edu.au/spppm/research/devpsych/actnow/factsheet15.html

Practitioners should have regard to these guidelines and the DSM-IV classification of pervasive developmental disorder in establishing the diagnosis and conducting the assessment.

For the management plan, a risk assessment involves assessment of the risk of a contributing co-morbidity as well as environmental, physical, social and emotional risk factors to the patient or to others.

The need for medication should also be considered where appropriate.

If the patient's care needs do not require a treatment and management plan, treatment can be provided under existing attendance items for consultant psychiatrists and paediatricians.

Referral requirements
Items 135 or 289 should be used for both diagnosis and treatment of autism or any other PDD where clinically appropriate. A consultant paediatrician or psychiatrist may claim any of items 110-131 or 296-370 (excluding 359), where appropriate, to seek assistance with diagnosis from an AHP.

The referral to an AHP for early intervention treatment must be made by a consultant paediatrician or psychiatrist, either as an outcome of the service provided under one of items 110-131, 296-370 (excluding 359), 135 or 289. There must be a claim for the patient for items 135 or 289 at the time of, or prior to the attendance for referral for AHP early intervention treatment.

Allied health assistance with diagnosis and treatment
An allied health professional may provide up to a maximum of four (4) services per child when providing assistance with assessment and diagnosis and up to a maximum of twenty (20) services for early intervention treatment.

Allied health diagnosis services may be provided to a child aged under 13 years. Allied health early intervention treatment services may be provided to a child aged under 15 years, if the PDD treatment plan prepared by a paediatrician or psychiatrist is complete prior to the child's 13th birthday.

Where the expertise of allied health professionals is drawn upon subsequent to a claim for items 135 or 289, any resulting review of the treatment and management plan should be completed under existing attendance items for consultant paediatricians or psychiatrists. For consultant paediatricians, this excludes item 133, which is exclusively for the review of a patient seen under item 132.

The extent of the services accessed by the consultant paediatrician or psychiatrist for diagnosis or early intervention treatment, and the decision regarding which allied health professionals to include, is a matter for the clinical judgement of the consultant paediatrician or psychiatrist.

Existing patients or patients with an existing diagnosis
Where a specific plan has not been created previously for the treatment and management of autism or any other PDD, a new plan can be developed by the treating practitioner under item 135 or 289 where it is clinically appropriate to treat the patient under such a plan.

Patients with an existing treatment and management plan created under item 135 or 289 can be reviewed under existing attendance items for consultant psychiatrists and paediatricians.

For further information on the patient's treatment progress and previous claims for consultant physician or allied health services, the treating practitioner may contact the Medicare provider line on 132 150.

A.26 HEALTHY KIDS CHECK (ITEMS 709 AND 711)

There is substantial national and international evidence that comprehensive early intervention programs for children and their families have long term benefits for physical and mental health, educational achievement and emotional functioning.

The purpose of the Healthy Kids Check is to ensure that every four year old child in Australia has a basic health check to see if they are healthy, fit and ready to learn when they start school. The Healthy Kids Check will promote early detection of lifestyle risk factors, delayed development and illness, and introduce guidance for healthy lifestyles and early intervention strategies. The Check will provide an opportunity to:

- issue parents/guardians with information and advice on healthy habits for life for children;
- link parents/guardians and children to the primary health care system;
- assist General Practitioners (GPs) and Practice Nurses to identify any health issues for children prior to starting school; and
- enable GPs to provide treatment or referral for any conditions identified as a result of the check.

Consent

Before the health check is commenced, the patient's parent/guardian must be given an explanation of the health check process and its likely benefits, and must be asked by the medical practitioner or nurse whether they consent to the health check being performed. Consent must be noted on the patient record.

Limits

A Medicare rebate is payable for this item only once for any eligible patient. This item is not an annual health check.

The GP or Practice Nurse is required to note if a copy of the Department's publication 'Get Set 4 Life – habits for healthy kids' has been provided to the patient's parents/guardian. The 'Get Set 4 Life – habits for healthy kits' guide is available from www.health.gov.au/epc

The GP or Practice Nurse is also required to note that the four year-old immunisation has been given (including evidence provided).

If a health professional is unsure whether a patient has already received this service, they may call Medicare Australia, with the patient's parent/guardian present, on 132 011.

Eligible practitioners

The health check can be claimed by a medical practitioner, including a GP but not including a specialist or consultant physician. The medical practitioner should generally be the patient's 'usual doctor', that is, the GP (or a GP in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months.

All GPs whether vocationally registered or not are eligible to claim this item. The term "GP" is used in these notes as a generic reference to medical practitioners able to claim this item.

The health check can also be undertaken on behalf of a GP by a practice nurse. The practice nurse is a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice.

Should the practice nurse identify any health concerns that require medical intervention, the patient must be reviewed by the patient's 'usual doctor' who will arrange referrals and follow-up as clinically required.

Items 709 and 711 do not apply for services that are provided by any other Commonwealth or State funded services. 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 709 and 711

can be claimed for services provided by medical practitioners or nurses salaried by or contracted to, the Service or health clinic. All requirements of the items must be met.

In all cases, the GP under whose supervision the health check is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse is appropriately qualified and trained to provide the service. GPs are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

General practices and Aboriginal Community Controlled Health Services and State/Territory health clinics that are exempt under subsection 19(2) of the *Health Insurance Act 1973* that utilise nurses to provide the Healthy Kids Check should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and general practitioners providing the Healthy Kids Check.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However, the GP should be able to be contacted if required.

Where the GP and practice nurse are at the same location, the GP is not required to be present while the Healthy Kids Check is undertaken. It is up to the GP to decide whether he or she needs to see the patient. Where the GP has a consultation with the patient that does not form part of the Healthy Kids Check, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance with the patient. The time the patient spends receiving a service from the practice nurse is itemised separately under item 711 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse provides another service (eg immunisation) on the same day, the GP is able to claim for both items.

In circumstances where the health check is not undertaken at the patient's usual medical practice, a copy of a record of the health check should be forwarded to that practice (subject to the agreement of the patient's parent/guardian).

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with items 709 and 711 provided the conditions of item 10990 and 10991 are satisfied (see explanatory note M.1.)

Components of the health check

The health check must include:

- information collection, including taking a patient history and undertaking examinations and investigations as required;
- the basic physical examinations and assessments (as outlined below);
- initiating interventions and/or referrals as indicated; and
- providing health advice and information to the patient's parents/guardian, utilising the Department's publication 'Get Set 4 Life – habits for healthy kids' and other relevant information (such as a parent/guardian-held child health record).

Information collection

The health check must include taking a patient history (if one does not already exist) or updating an existing record. It must include family and environmental factors, medical and social history, and lifestyle risk factors. Investigations should be undertaken or arranged as clinically indicated, in accordance with relevant guidelines.

Examinations and assessments (Mandatory)

The health check must include an assessment of the patient's health, based on the patient history, examinations and the results of any investigations (see *Information collection).*

In assessing the child's development, parents/guardians should be encouraged to provide relevant information through questions such as 'Do you have any concerns about your child's development? Behaviour? Learning? Or, concerning hearing/speech, 'Are you happy with the number of words your child uses and their understanding of directions?'

The health check must include the following basic physical examinations and assessments:

(a) Height and weight (plot and interpret growth curve/calculate BMI)

(b) Eyesight
(c) Hearing
(d) Oral health (teeth and gums)
(e) Toileting
(f) Allergies

Additional Matters for consideration)
The health check may include the following matters, at the discretion of the GP/practice nurse and according to his or her clinical judgement:

- General wellbeing
  (a) Diet
  (b) Physical activity
  (c) Lifestyle risk factors

- Developmental
  (d) Developmental milestones
  (e) Speech and language
  (f) Fine and gross motor skills
  (g) Behaviour and Mood

The Healthy Kids Check may also include examinations and investigations that are region-specific such as, but not limited to, trachoma and Rheumatic Heart Disease examinations in the Northern Territory and investigations designed to test for infections due to any recent, local outbreaks of infectious diseases (eg. measles).

Interventions
Where appropriate, arrangements need to be put in place for referrals and follow-up of any problems identified

A.29 TYPE 2 DIABETES RISK EVALUATION (ITEM 713)
The purpose of this item is to support general practitioners (GPs) to address the health needs of patients 40 to 49 years of age who are at '*high risk*' of developing type 2 diabetes. The 'high risk' score will be determined following the patient's completion of the Australian Type 2 Diabetes Risk Assessment Tool. The aim of this item is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

Clinical trials have provided strong evidence that progression to type 2 diabetes can be prevented or delayed by lifestyle modification. Randomised controlled trials in the United States and Finland have demonstrated reductions in the incidence of type 2 diabetes of 58% over 3 years in people with impaired glucose tolerance who received diet and exercise programs compared with control groups.

Many Australians, particularly those aged 40 – 49 years, are at risk of developing type 2 diabetes through lifestyle factors relating to nutrition and physical activity. Type 2 diabetes is a largely preventable chronic disease that is becoming increasingly common in Australia. If undetected or poorly controlled, type 2 diabetes can result in acute and long term complications. It is a leading cause of vascular disease (coronary artery disease, stroke and peripheral vascular disease), visual impairment and blindness, kidney failure, foot ulcers, amputation and impotence.

Eligible Population
The Type 2 Diabetes Risk Evaluation is targeted at people aged 40 to 49 years (inclusive) who are at high risk of developing type 2 diabetes.

Assessing a 'high risk' score and conducting a Type 2 Diabetes Risk Evaluation
The Type 2 Diabetes Risk Evaluation is a review of the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool.

Clinical factors that the GP should consider include:

- lifestyle, such as smoking, physical inactivity and poor nutrition;
- biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;
- any relevant recent diagnostic test results; and
- family history.

As part of a regular consultation (billed under the appropriate attendance item) a GP may suspect that a patient may have, or be at risk of developing diabetes. The GP may consequently order diagnostic tests to exclude the presence of type 2 diabetes. If diabetes is diagnosed, the GP may determine that a chronic disease management item is clinically relevant. If diabetes is not diagnosed, the GP may advise the patient to complete the Australian Type 2 Diabetes Risk Assessment Tool.

If the GP determines that the patient is not likely to have already developed diabetes, but the Australian Type 2 Diabetes Risk Assessment Tool indicates that the patient is at 'high risk', the GP may choose to undertake a Type 2 Diabetes Risk Evaluation during the same attendance (billed under item 713). If the preceding consultation was not exclusively related to diabetes risk assessment, and was a clinically relevant service (see *General Explanatory Note 1.2*), the appropriate attendance item may also be claimed.

Medicare Eligibility
A Medicare rebate is payable for the Type 2 Diabetes Risk Evaluation only once every three years for any eligible patient, or where more than three years has elapsed since item 717 has been claimed by that patient. If a GP is unsure whether a patient has already received this service, they may call Medicare Australia, with the patient present, on 132 011. The item does not apply to patients admitted to a hospital or day-hospital facility.

Eligible practitioners
The Type 2 Diabetes Risk Evaluation should generally be undertaken by the patient's 'usual doctor', that is, a medical practitioner, or a medical practitioner in the practice, who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months. A medical practitioner includes a general practitioner but not a specialist or consultant physician. In these notes, the term "GP" is used as a generic reference to a medical practitioner able to claim this item.

Components of the Type 2 Diabetes Risk Evaluation
The risk evaluation must include:

- evaluation of a 'high risk' score determined by the Australian Type 2 Diabetes Risk Assessment Tool, which has been completed by the patient within a period of 3 months prior to undertaking the Type 2 Diabetes Risk Evaluation service;
- updating a patient history and undertaking examinations and investigations in accordance with relevant guidelines (see below);
- making an overall assessment of the patient's risk factors, relevant examinations and the results of any investigations.
- initiating interventions where appropriate, including referrals and follow-up relating to the management of any risk factors identified; and
- providing advice and information (such as *Lifescripts* resources) to the patient including strategies to achieve lifestyle and behaviour changes where appropriate.

Australian Type 2 Diabetes Risk Assessment Tool
The Australian Type 2 Diabetes Risk Assessment Tool has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions that, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes. The item scores and risk rating calculations in the tool have been developed using demographic, lifestyle, anthropometric and biomedical data from the 2000 Australian Diabetes, Obesity and Lifestyle baseline survey and the AusDiab 2005 follow-up study.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from www.health.gov.au/epc.

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to the Type 2 Diabetes Risk Evaluation item. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible to attend a Type 2 Diabetes Risk Evaluation by their GP, and subsequent referral to the lifestyle modification programs if appropriate.

Lifestyle Modification Program
Eligible patients who have attended a diabetes risk evaluation with their GP, under this item, may be referred to a subsidised lifestyle modification program as one of a number of possible intervention strategies in addition to what may be available locally.

Where a service for an eligible patient has previously been billed under item 717, but within the specified three year period the risk of diabetes as measured by the Australian Type 2 Diabetes Risk Assessment Tool increases to 'high', the patient's GP may use his/her clinical judgement in a subsequent consultation to refer the patient to the lifestyle modification programs if it would provide health benefits.

Relevant resources on lifestyle modification are available at www.healthinsite.gov.au, including for patients who may not wish to attend or are unable to participate in a formal lifestyle modification program.

Role of the GP

The GP is responsible for the conduct of the Type 2 Diabetes Risk Evaluation provided to the patient. The GP is expected to take a primary role in the following activities:

- Reviewing and analysing the information collected (including the risk factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool);
- Making an overall assessment of the risk factors that contributed to the "high" risk score of the patient and their readiness to make lifestyle changes to address these identified risk factors;
- Undertaking and arranging relevant investigations;
- Making relevant referrals, including to lifestyle modification programs, and identifying appropriate follow-up; and
- Providing information and advice to the patient, for example, to undertake lifestyle modifications, and/or the use of Lifescript resources. Access to subsidised lifestyle modification programs will require the provision of a formal referral letter including the provider number of the referring GP.

Role of other health professionals

Practice nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the Type 2 Diabetes Risk Evaluation, in accordance with accepted medical practice and under the supervision of the GP.

This may include activities which:

- identify eligible patients through examination of patient records, patient information systems, and risk assessment tools used within the practice;
- collect information such as measuring height and weight (body mass index), waist circumference and blood pressure;
- provide patients with information about recommended interventions, and actions the patient should take (at the direction of the GP) to encourage good health.

Relationship with other GP consultation items

This diabetes risk evaluation item cannot be claimed in conjunction with another GP attendance item on the same day, except where this is clinically relevant (ie for a health issue unrelated to diabetes risk assessment).

Indigenous Australians are able to access the Aboriginal and Torres Strait Adult Health Check (MBS item 710) and a Type 2 Diabetes Risk Evaluation item if they meet the patient eligibility requirements. GPs are encouraged to use item 710 where appropriate because it covers a broad range of health issues including diabetes. Under item 710, GPs can refer patients with a high risk of developing type 2 diabetes to a subsidised lifestyle modificiation program. It is expected that item 710 covering ages 15-54 years, would negate the need for patients to have a separate Type 2 Diabetes Risk Evaluation. Patients eligible for item 710 are able to access the Type 2 Diabetes Risk Evaluation item 713 if they are in between health checks and if it has become clinically relevant for a Type 2 Diabetes Risk Evaluation to be conducted.

People aged 45 – 49 years (inclusive) are able to access the once only 45 year old health check (MBS item 717) if they are at risk of developing a chronic disease. Based on this consultation, if they have a high risk of type 2 diabetes, the GP is able to refer a person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

A person who has previously accessed an item 717 consultation, can only become eligible for a Type 2 Diabetes Risk Evaluation when three years have elapsed. A previous Item 713 Type 2 Diabetes Risk Evaluation does not preclude an eligible person from accessing Item 717 in relation to the risk of developing other chronic illnesses.

For patients with an existing chronic condition, the Chronic Disease Management (CDM) items (721-731) provide a suite of items for the management and review of chronic conditions. Patients with a care plan for a non-diabetes condition are able to access the Type 2 Diabetes Risk Evaluation item if they meet the patient eligibility requirements.

Guidelines
In considering and addressing risk factors, GPs are encouraged to utilise relevant guidelines and resources, such as:

- The RACGP publications: "*SNAP – a population health guide to behavioural risk factors in general practice"*; *"Putting Prevention into Practice"* (the Green Book); and *"Guidelines for Preventive Activities in General Practice"* (the Red Book).

The National Health and Medical Research Council's approved guidelines *National Evidence Based Guidelines for the Management of Type 2 Diabetes Mellitus - Primary Prevention of Type 2 Diabetes.*

T2.5 Radiation Oncology Treatment Verification (Items 15700, 15705 and 15800)
In these items, 'treatment verification' means:
a quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiation therapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:
(a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)
(b) computed tomography; or
(c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered);
together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

Treatment sites are 'non-contiguous' if each site encompasses a separate and distinct planning tumour volume and the treatment plan for each site is independent of other treatment sites.

Item 15700 covers the acquisition of images in one plane and incorporates both single or double exposures. The item may be itemised once only per treatment site. Hence two exposures of a single plane image of a single treatment site would be itemised 15700 X 1.

Item 15700 may be itemised for each treatment site that is being verified at the same treatment session. For example, if the patient is being treated for four metastases in the spine, both legs and an arm, and single plane images are undertaken to verify the treatment location of all four sites, the account would be itemised 15700 X 4.

Item 15705 (multiple projections) applies where images in more that one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only once per treatment site to a maximum of three non-contiguous treatment sites per treatment session. Using the example shown for 15700, except that multiple projections are taken at each treatment site, benefits would only be payable for 15705 X 3.

Item 15705 also applies where single projections of contiguous treatment sites are acquired, for example, breast tangents plus the supra clavicular region.

T2.6 Brachytherapy Planning and Verification (Items 15800)
Item 15800 - Benefits are payable once only per attendance at which treatment is verified.

Item 15850 - This item covers radiation source localisation for high dose brachytherapy treatment. It is based on an existing item (Item 15513) for prostate seed implant brachytherapy. Item 15850 applies to brachytherapy provided to any part of the body.

T7.5 Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under items 18354, 18356, or 18358 for a dynamic foot deformity.

T8.77 Imbedded Foreign Body (Item 42644)
T8.77 For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.
T8.77 Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.
T8.77 Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

T8.80 Posterior Juxtascleral Depot injection (Item 42741)

T8.80 For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

T10.28 Anaesthesia for microvascular free tissue flap surgery (Items 20230, 20355, 20475, 20704, 20905, 21155, 21275, 21455, 21535, 21685, 21785, 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implantation of digits on either the hand or the foot.

T10.29 Anaesthesia Agent Allergy testing (Item 21981)

Benefits are only payable under item 21981 where anaesthetic agent allergy is suspected following anaphylactic or anaphylactoid reaction to anaesthetic agents or cardiovascular collapse in association with anaesthesia.

T10.30 Anaesthesia for endoscopic ureteric surgery – including laser procedure (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

T11.1 Botulinum Toxin (Items 18350 - 18373)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is registered by Medicare Australia to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of Botulinum Toxin.

Items 18354, 18356 and 18358 for the treatment of equinus, equinovarus or equinovalgus are limited to a maximum of 4 injections per patient on any one day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Botulinum Toxin, which is not supplied and administered in accordance with the arrangements under Section 100 of the *National Health Act 1953*, is not free of charge to patients. Where a charge is made for the Botulinum Toxin administered, it must be separately listed on the account and not billed to Medicare

M.6.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO CLINICAL PSYCHOLOGISTS FOR PSYCHOLOGICAL THERAPY)

Referrals

Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Care Plan (item 2710); or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

M.7.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by a GP managing the patient under a GP Mental Health Care Plan (item 2710), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

M10 PROVISION OF PERVASIVE DEVELOPMENTAL DISORDER SERVICES BY ALLIED HEALTH PROFESSIONALS

OVERVIEW OF THE PERVASIVE DEVELOPMENTAL DISORDER ITEMS

MBS items (82000 to 82025) are available for allied health professional services for children (aged under 13 years for diagnosis and under 15 years for treatment) with autism or any other pervasive developmental disorder (PDD). These items apply to services provided by eligible psychologists, speech pathologists and occupational therapists, on referral from a consultant psychiatrist or paediatrician. These items cover two specific types of service that allow the relevant allied health professionals to:

- assist the referring practitioner in the diagnosis of the child ─ aged under 13 years ─ and/or development of the child's PDD treatment plan (items 82000, 82005 and 82010); and
- provide treatment to the child ─ aged under 15 years (and who was aged under 13 years at the time of receiving their PDD treatment plan) for their particular condition, consistent with the treatment plan prepared by the referring practitioner (items 82015, 82020 and 82025).

ASSESSMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health assessment services

There are three MBS items available for eligible psychologists, speech pathologists and occupational therapists to assist a referring practitioner in the diagnosis of a child (aged under 13 years) and/or preparation of a PDD treatment plan for that child. Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out below (see 'Eligible allied health professionals' section) and be registered with Medicare Australia.

Services provided for assisting in the diagnosis of a child and/or preparation of a PDD treatment plan for the child will not attract a Medicare rebate unless:

- a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see 'REFERRAL REQUIREMENTS' section) who, as part of the referral, requests the allied health professional's assistance in assessing the patient and/or preparing a treatment plan for the patient.

Number of services

Medicare rebates are available for up to four (4) allied health assessment services in total per eligible child. The four services may consist of any combination of items 82000, 82005 and 82010. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual needs and to refer the child to appropriate allied health professional(s) accordingly.

TREATMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health treatment services

There are three MBS items available for eligible psychologists, speech pathologists and occupational therapists to provide treatment services to eligible children ─ aged under 15 years (and who were aged under 13 years at the time of receiving a PDD treatment plan) ─ with a PDD. Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out below (see 'Eligible allied health professionals' section) and be registered with Medicare Australia.

Services provided for the treatment of children with a PDD will not attract a Medicare rebate unless:

- a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see 'REFERRAL REQUIREMENTS' section) who is managing the child under a PDD treatment plan (item 135 or 289);

Number of services

Medicare rebates are available for up to twenty (20) allied health treatment services in total per eligible child. The twenty services may consist of any combination of items 82015, 82020 and 82025. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

Please note that these conditions apply to both the assessment (items 82000-82010) and treatment (items 82015-82025) services.

Service length and type

Services under these items must be for the time period specified within the item descriptor. The allied health professional must personally attend the child.

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

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the PDD treatment plan prepared by the psychiatrist or paediatrician, and in keeping with commonly established PDD interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Course of treatment and reporting back to the referring practitioner

Children are eligible to receive up to a total of four (4) PDD assessment services and twenty (20) PDD treatment services with an eligible allied health professional(s).

A written report must be provided to the referring consultant psychiatrist or paediatrician by the allied health professional(s) after having provided the PDD assessment service(s) to the child.

Within the maximum service allocation of twenty services for the PDD treatment items, the allied health professional(s) can provide one or more courses of treatment. For the purposes of these services, a course of treatment will consist of the number of services stated on the child's referral (up to a maximum of 10). This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

On completion of the course of treatment, the eligible psychologist, speech pathologist and occupational therapist must provide a written report to the referring consultant psychiatrist or paediatrician which includes information on:

- treatment provided;
- recommendations on future management of the child's disorder;
- any advice provided to third parties (eg. parents, schools).

A written report must also be provided to the referring consultant psychiatrist or paediatrician at the completion of any subsequent course(s) of treatment provided to the child.

Out of pocket expenses and Medicare safety net
Charges in excess of the Medicare benefit for these items are the responsibility of the patient. Such out-of-pocket costs will count toward the Medicare safety net for that patient. Any allied health PDD assessment services that are in excess of the maximum of four (4) and any allied health PDD treatment services that are in excess of the maximum of twenty (20) allowable per child will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the child for such services.

Eligible patients
These MBS services apply to children ─ aged under 13 years ─ where the child is referred by an eligible consultant psychiatrist or paediatrician, for assessment items 82000-82010 inclusive. The MBS treatment services apply to children ─ aged under 15 years (where the child was aged under 13 years at the time of receiving a PDD treatment plan) ─ for treatment items 82015-82025 inclusive.

The conditions classified as PDD for the purposes of these services are informed by the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition (DSM-IV-TR), Washington, DC, American Psychiatric Association, 2000.*

Checking patient eligibility for allied health pervasive developmental disorder services
Patients seeking Medicare rebates for the allied health PDD services will need to have a referral from a consultant psychiatrist or paediatrician. If there is any doubt about a child's eligibility, Medicare Australia will be able to confirm whether a relevant psychiatric or paediatric MBS service has been claimed (to facilitate access to the assessment items); or that a PDD treatment plan has been claimed (to facilitate access to the treatment items), as well as the number of allied health PDD services already claimed by the child.

Allied health professionals can call Medicare Australia on 132 150 to check this information. Parents and carers can seek clarification by calling 132 011.

The child will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the child's eligibility. In this case the allied health professional should, with the permission of the child's parent or carer, contact the referring consultant psychiatrist or paediatrician to ensure the relevant service has been provided to the child.

Publicly funded services
Allied health PDD assessment and treatment items 82000 to 82025 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 a direction under subsection 19(2) of the *Health Insurance Act 1973* has been made in regard to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible allied health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services.)

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

REFERRAL REQUIREMENTS (PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED HEALTH PROFESSIONALS)

Referrals
Referrals from consultant psychiatrists and paediatricians to allied health professionals for the PDD assessment items must be made from eligible Medicare services.

An eligible allied health professional can provide PDD assessment items (82000-82010) to a child where:

- the child has previously been provided with any MBS service covering items 110 through 131 inclusive, as provided by an eligible consultant paediatrician; or

- the child has previously been provided with any MBS service covering items 296 through 370 (excepting item 359) inclusive, as provided by an eligible consultant psychiatrist.

An eligible allied health professional can provide PDD treatment items (82015-82025) to a child where:

- the child has previously been provided with a PDD treatment plan (MBS item 135) by an eligible consultant paediatrician; or
- the child has previously been provided with a PDD treatment plan (MBS item 289) by an eligible consultant psychiatrist.

An allied health professional wanting to provide any of the items 82000-82025 must be in receipt of a current referral provided by a consultant physician paediatrician or a consultant physician psychiatrist. With specific regard to the treatment items, a patient must have a previous claim for item 135 or 289.

Referring consultant paediatricians and consultant psychiatrists are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.
The allied health professional must be in receipt of the referral at the initial consultation. Allied health professionals are required to retain the referral for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity
Medicare benefits are available for up to four (4) allied health PDD assessment and up to twenty (20) allied health PDD treatment services per patient.
Patients will require a separate referral for each allied health professional they receive services from and will also need fresh referrals for each new course of treatment provided to them.

PSYCHOLOGIST, SPEECH PATHOLOGIST AND OCCUPATIONAL THERAPIST PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
Allied health professionals providing services under these items must be registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied health professional must be:

- A psychologist registered, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising. (Psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use the items); or
- A speech pathologist (in Queensland) registered with the Speech Pathologist Board of Queensland. In all other States and Territories, participating speech pathologists must be a 'Practising member' of Speech Pathology Australia; or
- An occupational therapist in Queensland, Western Australia, South Australia or the Northern Territory who is registered with the Occupational Therapists Board in the State or Territory in which they are practising. In other States and the Australian Capital Territory, the occupational therapist must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

In addition to meeting the above mentioned credentialing requirements, it is expected that eligible providers will "self-select" for the pervasive developmental disorder items (that is, possess the skills and experience appropriate for provision of these services and be oriented to work with children with PDD).

Registering with Medicare Australia
Advice about registering with Medicare Australia to provide allied health professional services using items 82000-82025 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

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.

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

SUMMARY OF CHANGES TO THE PATHOLOGY SERVICES TABLE

Group P2 – Chemical
Deletion of items 66515 and 66710.
Items 66512 and 66707 have been amended to include the words 5 "or more tests".
Addition of a new item 66830 for the quantitation of BNP or NT-pro BNP for the diagnosis of heart failure in patients presenting with dyspnoea in a hospital Emergency Department.

Group P3 - Microbiology
Deletion of item 69399.
Item 69396 has been amended to include the words 5 "or more tests".
Addition of a new item 69482 for the quantitation of hepatitis B viral DNA in patients who are hepatitis B surface antigen positive and have chronic hepatitis B but are not receiving antiviral therapy; and
Addition of a new item 69483 for quantitation of hepatitis B viral DNA in patients who are hepatitis B surface antigen positive, have chronic hepatitis B and are receiving antiviral therapy.

Group P10 – Patient Initiation Fee
Addition of new item 73920 for initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre that the APA operates in the same premises as it operates a category GX or GY pathology laboratory.

An amendment has been made to item 73928 to include reference to the new PEI item 73920.

Rules
Rules 4(1), 4(2)(e), 6(2)(b) and 16(3) have been amended to remove the reference to the items that have been deleted.

Limitation on certain items

25.
(a) For any particular patient, items 66539, 66605, 66606, 69419, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.
(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.
(c) For any particular patient, items 66655, 66659, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.
(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.
(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.
(f) For any particular patient, items 66551, 69445, 69451, 69483, 71079, or 73314, 73315, 73523 are applicable not more than 4 times in a 12 month period.
(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.
(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.
(i) For any particular patient, item 69418 is applicable not more than twice in a 24 month period.

Outline of Arrangements
The Outline of Arrangements has been amended to reflect recent changes to item numbers.

SUMMARY OF CHANGES

The 1 July 2008 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

135 289 709 711 713 15700 15705 15800 15850 20147 20230 20355 20475 20704 20863 20905 20911 21155 21275 21445 21535 21685 21785 21865 21981 42741 66830 69482 69483 73920 82000 82005 82010 82015 82020 82025

Deleted Items

66515 66710 69399

Amended Description

16018 18292 20942 22007 23010 30487 35700 37616 37619 42644 49503 49506 59736 66512 66707 69396 73928

Anaesthetic Unit Values Amended

20920

Fee Amended

20920

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 July 2008 and continues beyond that date, the old (1 November 2007) 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 July 2008

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, 709, 710, 711, 712, 713, 714, 716, 717, 718, 719
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 M2	Services provided by a practice nurse on behalf of a medical practitioner	10993, 10994, 10995, 10996, 10997, 10998, 10999
Group M5	Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner	10988, 10989

	GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	CONSULTANT PAEDIATRICIAN, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL Professional attendance of at least 45 minutes duration by a consultant physician in his or her specialty of paediatrics, for assessment, diagnosis and the preparation of a treatment and management plan for a patient aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant paediatrician by a medical practitioner, where the consultant paediatrician: (a) undertakes a comprehensive assessment of the patient and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan that contains: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate care pathways; and (vi) appropriate medication recommendations, where necessary. (c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate). Not being an attendance on a patient in respect of whom payment has previously been made under this item or item 289.
† 135	*(See para A.13 of explanatory notes to this Category)* **Fee:** $238.30 **Benefit:** 75% = $178.75 85% = $202.60
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL Professional attendance of at least 45 minutes duration by a consultant physician in his or her specialty of psychiatry, for assessment, diagnosis and the preparation of a treatment and management plan for a patient aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant psychiatrist by a medical practitioner, where the consultant psychiatrist: (a) undertakes a comprehensive assessment of the patient and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan that contains: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate care pathways; and (vi) appropriate medication recommendations, where necessary. (c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate). Not being an attendance on a patient in respect of whom payment has previously been made under this item or item 135.
† 289	*(See para A.13 of explanatory notes to this Category)* **Fee:** $238.30 **Benefit:** 75% = $178.75 85% = $202.60

ENHANCED PRIMARY CARE	**ENHANCED PRIMARY CARE**
	GROUP A14 - HEALTH ASSESSMENTS
† 709	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** to undertake a health check for a patient who is receiving or has received their four year old immunisation. Not being an attendance on a patient in respect of whom a payment has already been made under this item or item 711. Benefits are payable on one occasion only for each eligible patient. *(See para A.26 of explanatory notes to this Category)* **Fee:** $45.00 **Benefit:** 100% = $45.00
† 711	Service provided by a practice nurse being the provision of a health check for a patient who is receiving or has received their four year old immunisation, if : (a) the service is provided on behalf of, and under the supervision of, a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), and (b) the person is not an admitted patient of a hospital. Not being an attendance on a patient in respect of whom a payment has already been made under this item or item 709. Benefits are payable on one occasion only for each eligible patient. *(See para A.26 of explanatory notes to this Category)* **Fee:** $45.00 **Benefit:** 100% = $45.00
† 713	Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) **AT A PLACE OTHER THAN A HOSPITAL** to undertake a type 2 diabetes risk evaluation for a patient who is 40 to 49 years of age (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool – not being a type 2 diabetes risk evaluation of a patient in respect of whom, in the preceding 3 years, a payment has been made under this item or item 717. *(See para A.29 of explanatory notes to this Category)* **Fee:** $60.00 **Benefit:** 100% = $60.00
RADIATION ONCOLOGY	**RADIATION ONCOLOGY TREATMENT**
	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION
† 15700	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) – each non-contiguous treatment site verified. *(See para T.2 of explanatory notes to this Category)* **Fee:** $43.90 **Benefit:** 75% = $32.95 85% = $37.35
† 15705	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection or volumetric acquisition – each non-contiguous treatment site verified to a maximum of 3 sites per attendance. *(See para T.2 of explanatory notes to this Category)* **Fee:** $73.20 **Benefit:** 75% = $54.90 85% = $62.25
	SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION
† 15800	BRACHYTHERAPY TREATMENT VERIFICATION – maximum of one only for each attendance. *(See para T.2 of explanatory notes to this Category)* **Fee:** $92.05 **Benefit:** 75% = $69.05 85% = $78.25
† 15850	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies. **Fee:** $190.60 **Benefit:** 75% = $142.95 85% = $162.05
THERAPEUTIC NUCLEAR MEDICINE	**THERAPEUTIC NUCLEAR MEDICINE**
	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
‡ 16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $2,205.70 **Benefit:** 75% = $1,654.30 85% = $2,140.50

	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
‡ 18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which items 18354, 18356 and 18358 applies (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $112.75 **Benefit:** 75% = $84.60 85% = $95.85
RELATIVE VALUE GUIDE	
	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 1 - HEAD
† 20147	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for squint repair (6 basic units) **Fee:** $107.40 **Benefit:** 75% = $80.55 85% = $91.30
† 20230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the head or face (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $214.80 **Benefit:** 75% = $161.10 85% = $182.60
	SUBGROUP 2 - NECK
† 20355	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the neck (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $214.80 **Benefit:** 75% = $161.10 85% = $182.60
	SUBGROUP 3 - THORAX
† 20475	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 6 - UPPER ABDOMEN
† 20704	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 7 - LOWER ABDOMEN
† 20863	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for nephrectomy (10 basic units) **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 8 - PERINEUM
† 20905	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the perineum (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
† 20911	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endoscopic ureteroscopic surgery including laser procedures (5 basic units) *(See para T10.30 of explanatory notes to this Category)* **Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10
+ 20920	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90

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‡ 20942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10
	SUBGROUP 9 - PELVIS (EXCEPT HIP)
† 21155	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)
† 21275	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 11 - KNEE AND POPLITEAL AREA
† 21445	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 12 - LOWER LEG (BELOW KNEE)
† 21535	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the lower leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 13 - SHOULDER AND AXILLA
† 21685	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 14 - UPPER ARM AND ELBOW
† 21785	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 15 - FOREARM WRIST AND HAND
† 21865	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
	SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
† 21981	**ANAESTHETIC AGENT ALLERGY TESTING**, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse in association with the administration of anaesthesia agents (4 basic units) *(See para T10.29 of explanatory notes to this Category)* **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90

	SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES
‡ 22007	**ENDOTRACHEAL INTUBATION** with flexible fibreoptic scope associated with difficult airway **when performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90
	SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS
‡ 23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997, 21981 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $17.90 **Benefit:** 75% = $13.45 85% = $15.25
OPERATIONS	
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
‡ 30487	SMALL BOWEL INTUBATION with biopsy, as an independent procedure (Anaes.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $163.35 **Benefit:** 75% = $122.55 85% = $138.85
	SUBGROUP 4 - GYNAECOLOGICAL
‡ 35700	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.) **Fee:** $659.35 **Benefit:** 75% = $494.55
	SUBGROUP 5 - UROLOGICAL
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
‡ 37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $624.40 **Benefit:** 75% = $468.30
‡ 37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $249.80 **Benefit:** 75% = $187.35 85% = $212.35
	SUBGROUP 9 - OPHTHALMOLOGY
‡ 42644	CORNEA OR SCLERA, removal of imbedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
† 42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $271.60 **Benefit:** 75% = $203.70 85% = $230.90

	SUBGROUP 15 - ORTHOPAEDIC
	KNEE
‡ 49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 1 procedure (Anaes.) (Assist.) **Fee:** $442.10 **Benefit:** 75% = $331.60
‡ 49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 2 or more procedures (Anaes.) (Assist.) (Anaes.) (Assist.) **Fee:** $663.20 **Benefit:** 75% = $497.40
DIAGNOSTIC RADIOLOGY	**OPAQUE/CONTRAST MEDIA**
	GROUP I3 - DIAGNOSTIC RADIOLOGY
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
‡ 59736	VASOEPIDIDYMOGRAPHY, 1 side, - (R) **Fee:** $62.00 **Benefit:** 75% = $46.50 85% = $52.70
PATHOLOGY	**PATHOLOGY**
	GROUP P2 - CHEMICAL
‡ 66512	5 or more tests described in item 66500 **Fee:** $17.80 **Benefit:** 75% = $13.35 85% = $15.15
‡ 66707	5 or more tests described in item 66695 (Item is subject to rule 6) **Fee:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35
† 66830	Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department (Item is subject to rule 25) Fee: $59.55 Benefit: 75% = $44.70 85% = $50.65
	GROUP P3 - MICROBIOLOGY
‡ 69396	5 or more tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP.7 and PP.13 of explanatory notes to this Category)* **Fee:** $69.55 **Benefit:** 75% = $52.20 85% = $59.15
† 69482	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and have chronic hepatitis B, but are not receiving antiviral therapy - 1 test (Item is subject to rule 25) Fee: $153.10 Benefit: 75% = $114.85 85% = $130.15
† 69483	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and who have chronic hepatitis B and are receiving antiviral therapy - 1 test (Item is subject to rule 25) Fee: $153.10 Benefit: 75% = $114.85 85% = $130.15

	GROUP P10 - PATIENT EPISODE INITIATION
† 73920	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre that the APA operates in the same premises as it operates a category GX or GY pathology laboratory **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
‡ 73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies **Fee:** $17.40 **Benefit:** 75% = $13.05 85% = $14.80

	GROUP 10 - PERVASIVE DEVELOPMENTAL DISORDER SERVICES
† 82000	**PSYCHOLOGY** Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005 and 82010 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $90.15 **Benefit:** 85% = $76.65
† 82005	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005 and 82010 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $79.40 **Benefit:** 85% = $67.50
† 82010	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005 and 82010 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $79.40 **Benefit:** 85% = $67.50

	PSYCHOLOGY Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible psychologist where: (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020 and 82025
† 82015	*(See para M10.1 of explanatory notes to this Category)* **Fee:** $90.15 **Benefit:** 85% = $76.65
	SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible speech pathologist where: (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020 and 82025
† 82020	*(See para M10.1 of explanatory notes to this Category)* **Fee:** $79.40 **Benefit:** 85% = $67.50
	OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible occupational therapist where: (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020 and 82025
† 82025	*(See para M10.1 of explanatory notes to this Category)* **Fee:** $79.40 **Benefit:** 85% = $67.50