Medicare Benefits Schedule

Summary of Changes

Effective 1 May 2010

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Summary of Additions, Deletions, and Revisions undertaken since 1 January 2010

New Items are indicated as “New”. Deleted items are indicated as “Del”.

Amended items are indicated as “Amend” Within revised items, the deleted language appears with a ~~double strikethrough~~ while new text appears underlined. These changes will be highlighted in yellow.

Note: Revisions to the headings, notes, introductory paragraphs, and cross references are not included in this summary of changes.

New Items (New)

1 May 2010

597	598	599	600	701	703	705	707	
715	732	735	739	743	747	750	758	
10985	10986	15710	36663	36664	36665	36666	36667	36668
73290	73291	73292	73293	73294				

1 January 2010

2702	13201	13202	16401	16404	16591	58120	58121	

Deleted Items (Del)

1 May 2010

1	2	13	19	25	33	38	40	48
50	81	83	84	86	87	89	90	91
97	98	601	602	603	696	697	698	700
702	704	706	708	709	710	711	712	713
714	716	717	718	719	725	727	734	736
738	740	742	744	746	749	757	759	762
765	768	771	773	775	778	779	5007	5026
5046	5064	5240	5243	5247	5248			

Amended Description (Amend)

1 May 2010

3	4	20	23	24	35	36	37	43
44	47	51	58	59	60	65	173	193
195	197	199	410	411	412	413	414	415
416	417	721	723	729	731	2497	2501	2503
2504	2506	2507	2509	2517	2518	2521	2522	2525
2526	2546	2547	2552	2553	2558	2559	5000	5003
5010	5020	5023	5028	5040	5043	5049	5060	5063
5067	5220	5223	5227	5228	5260	5263	5265	5267
15700	15705	18354	18356	18358	30479	32087	32093	73287
73289	81100	81110	81120	81300				

1 January 2010

104	2710	2712	2713	13200	13203	13206	13209	13212
13215	13218	13221	13251	16590	63464			

Assist (Added)

No assist added to items.

Amended Fee

1 May 2010

36	44	197	199	412	413	2504	2507	2521
2525	2552	2558	5040	5060				

1 January 2010

13200	13203	13206	13209	13212	13215	13218	13221	13251
16400	16500	16502	16504	16505	16508	16509	16515	16518
16519	16520	16522	16525	16590	58108	58115		

EMSN Cap (EMSN)

1 January 2010

13200	13203	13206	13209	13212	13215	13218	13221	13251
16400	16500	16501	16502	16504	16505	16508	16509	16511
16512	16514	16515	16518	16519	16520	16522	16525	16564
16567	16570	16571	16573	16590	16600	16603	16606	16609
16618	16624	16627	16633	16636	32500	45560	55700	55703
55704	55705	55706	55707	55708	55709	55712	55715	55718
55721	55723	55725	55729	55762	55764	55766	55768	55770
55772	55774							

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Category 1 – Professional Attendances

ATTENDANCES	ATTENDANCES
	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	LEVEL A Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Amend **3**	~~Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms.~~)~~ *(See para A5 of explanatory notes to this Category)* **Fee:** $15.70 **Benefit:** 100% = $15.70
Amend **4**	~~HOME VISIT~~ ~~(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)~~ ~~*(See para A5 of explanatory notes to this category)*~~ **HOME VISIT OR CONSULTATION AT AN INSTITUTION (INCLUDING A HOSPITAL) OTHER THAN A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.80 per patient.
Amend **20**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion~~)~~ each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $3.10 per patient.

	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend **23**	~~Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which items 36, 37, 38, 40, 43, 44, 48, 50 or 51 applies~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~ *(See para A5 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 100% = $34.30
Amend **24**	~~**HOME VIST**~~ ~~(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)~~ ~~*(See para A5 of explanatory notes to this Caregory)*~~ **HOME VISIT OR CONSULTATION AT AN INSTITUTION (INCLUDING A HOSPITAL) OTHER THAN A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.80 per patient.
Amend **35**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion~~)~~ each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $3.10 per patient.

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ATTENDANCES	ATTENDANCES
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **36**	~~Professional attendance involving taking a detailed history, examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which items 44, 48, 50 or 51 applies~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms.~~)~~ *(See para A5 of explanatory notes to this Category)* **Fee:** ~~$65.20~~ $66.45 **Benefit:** 100% = ~~$65.20~~ $66.45
Amend **37**	~~**HOME VISIT**~~ ~~(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residental aged care facility or institution)~~ ~~*(See para A5 of explanatory notes to this Category)*~~ **HOME VISIT OR CONSULTATION AT AN INSTITUTION (INCLUDING A HOSPITAL) OTHER THAN A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.80 per patient.
Amend **43**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion~~)~~ each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $3.10 per patient.

	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **44**	~~Professional attendance involving taking an exhaustive history, a comprehensive examination if multiple systems, arranging for any necessary investigations and implementing a management planin relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms.~~)~~ *(See para A5 of explanatory notes to this Category)* **Fee:** ~~$95.95~~ $97.80 **Benefit:** 100% = ~~$95.95~~ $97.80
Amend **47**	~~**HOME VISIT**~~ ~~(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms , hospital, residential aged care facility or institution)~~ ~~*(See para A5 of explanatory notes to this Category)*~~ **HOME VISIT OR CONSULTATION AT AN INSTITUTION (INCLUDING A HOSPITAL) OTHER THAN A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.80 per patient.
Amend **51**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion~~)~~ each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $3.10 per patient.

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ATTENDANCES	OTHER NON-REFERRED
	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 1 - OTHER MEDICAL PRACTITIONER ATTENDANCES
	HOME VISIT OR CONSULTATION AT AN INSTITUTION (INCLUDING A HOSPITAL) OTHER THAN A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility.
Amend **58**	~~**HOME VISITS**~~ ~~(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)~~ **BRIEF** ~~**HOME VISIT**~~ **CONSULTATION** of not more than 5 minutes duration **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient.
Amend **59**	**STANDARD** ~~**HOME VISIT**~~ **CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient.
Amend **60**	**LONG** ~~**HOME VISIT**~~ **CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient.
Amend **65**	**PROLONGED** ~~**HOME VISIT**~~ **CONSULTATION** of more than 45 minutes duration **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient.

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	GROUP A7 - ACUPUNCTURE
Amend **173**	**LEVEL A** ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A17 of explanatory notes to this Category)* **Fee:** $21.65 **Benefit:** 75% = $16.25100% = $21.65
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend **193**	~~Professional attendance by a general practitioner who is a qualified medical acupuncturist,~~ ~~**at a place other than a hospital**~~, ~~involving either:~~ ~~(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems;OR~~ ~~(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36,37,38,40,43,44,47,48,50 or 51 applies~~ **CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital ~~AND~~ at which ACUPUNCTURE is performed ~~by the general practitioner~~ by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A17 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 100% = $34.30
Amend **195**	~~Professional attendance by a general practitioner who is a qualified medical acupuncturist,~~ ~~**on 1 or ore patients at a hospital**~~, ~~on one occasion, involving either:~~ ~~(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR~~ ~~(ii) a professional attendance of less than 20 minutes duration involving components of a sevice to which item 3;6, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies~~ **CONSULTATION AT A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a hospital on one or more patients on one occasion ~~AND~~ at which ACUPUNCTURE is performed ~~by the general practitioner~~ by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A17 of explanatory notes to this Category)* **Derived Fee:** The fee for item 193, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $1.80 per patient.

	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **197**	~~Professional attendance by a general practitioner who is a qualified medical acupuncturist, **at a place other than a hospital**, involving either:~~ ~~(i) taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes;~~ ~~OR~~ ~~(ii) a professional attendance of at least 20 minutes but less than 40 minutes duration involving components of a service to which item 44,47,48,50 and 51 applies~~ **CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital ~~AND~~ at which ACUPUNCTURE is performed ~~by the general practitioner~~ by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A17 of explanatory notes to this Category)* **Fee:** ~~$65.20~~ $66.45 **Benefit:** 100% = ~~$65.20~~ $66.45
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **199**	~~Professional attendance by a general practitioner who is a qualified medical acupuncturist, **at a place other than a hospital**, involving either:~~ ~~(i) taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes;~~ ~~OR~~ (ii) ~~a professional attendance of at least 40 minutes duration for implementation of a management plan~~ **CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital ~~AND~~ at which ACUPUNCTURE is performed ~~by the general practitioner~~ by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A17 of explanatory notes to this Category)* **Fee:** ~~$95.95~~ $97.80 **Benefit:** 100% = ~~$95.95~~ $97.80

PUBLIC HEALTH	PUBLIC HEALTH
	GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine
Amend **410**	**LEVEL A** (Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine) - Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. *(See para ~~A36~~ A39 of explanatory notes to this Category)* **Fee:** $18.45 **Benefit:** 75% = $13.85 85% = $15.70
Amend **411**	**LEVEL B** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking a patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to ~~one~~ 1 or more ~~health related~~ health-related issues, with appropriate documentation. ~~Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 412 applies~~ (see para ~~A36~~ A39 of explanatory notes to this Category) **Fee:** $40.40 **Benefit:** 75% = $30.30 85% = $34.35
Amend Fee **412**	**LEVEL C** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking a detailed patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to ~~one~~ 1 or more ~~health related~~ health-related issues, with appropriate documentation. ~~Attendance involving taking a detailed history, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies~~ (see para ~~A36~~ A39 of explanatory notes to this Category) **Fee:** ~~$76.65~~ $78.10 **Benefit:** 75% = ~~$57.50~~ $58.60 85% = ~~$65.20~~ $66.40

Amend Fee **413**	**LEVEL D** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking an extensive patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to ~~one~~ 1 or more ~~health related~~ health-related issues, with appropriate documentation. ~~- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implentmenting a managemnet plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implemcntation of a management plan~~ (see para ~~*A36*~~ *A39* of explanatory notes to this Category) **Fee:** ~~$112.90~~ $115.05 **Benefit:** 75% = ~~$84.70~~ $86.30 85% = ~~$96.00~~ $97.80
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS Professional attendance other than at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine
Amend **414**	**LEVEL A** ~~**PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS**~~ ~~(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)~~ ~~-~~Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (see para ~~A36~~ A39 of explanatory notes to this Category) **Derived Fee:** The fee for item 410, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $1.80 per patient.
Amend **415**	**LEVEL B** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking a patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to ~~one~~ 1 or more ~~health related~~ health-related, with appropriate documentation. (see para ~~A36~~ A39 of explanatory notes to this Category) **Derived Fee:** The fee for item 411, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $1.80 per patient.

Amend **416**	**LEVEL C** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking a detailed patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. ~~- Attendance involving taking a detailed history, an examination of multiple sustems, arranging any necessary investigations and implementing a managemnet plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 417 applies~~ (see para ~~A36~~ A39 of explanatory notes to this Category) **Derived Fee:** The fee for item 412, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $1.80 per patient.
Amend **417**	**LEVEL D** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking an extensive patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. ~~- Attendance involving taking an exhaustive history, a comprehensive examination of multiple sustems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 0 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan~~ (see para ~~A36~~ A39 of explanatory notes to this Category) **Derived Fee:** The fee for item 413, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $1.80 per patient.

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	GROUP A11 - URGENT ATTENDANCE AFTER HOURS
	SUBGROUP 1 - URGENT ATTENDANCE - AFTER HOURS
New **597**	Professional attendance by a general practitioner on not more than 1 patient on the 1 occasion – each attendance ***(other than an attendance between 11pm and 7am)*** in an after-hours period if: a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken urgent after-hours period; b) the patient's condition requires urgent medical treatment; and c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $120.30 **Benefit:** 75% = $90.25100% = $120.30
New **598**	Professional attendance by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance ***(other than an attendance between 11pm and 7am)*** in an after-hours period if: a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken urgent after-hours period; b) the patient's condition requires urgent medical treatment; and c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance. **Fee:** $104.75 **Benefit:** 75% = $78.60100% = $104.75
	SUBGROUP 2 - URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
New **599**	Professional attendance, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance ***between 11pm and 7am***, if: a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's condition requires urgent medical treatment; and c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open, the consulting rooms for the attendance. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $141.75 **Benefit:** 75% = $106.35 100% = $141.75
New **600**	Professional attendance, by a medical practitioner, (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance ***between 11pm and 7am***, if: a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and b) the patient's condition requires urgent medical treatment; and c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open, the consulting rooms for the attendance. *(See para A10 of explanatory notes to this Category)* **Fee:** $124.25 **Benefit:** 75% = $93.20100% = $124.25

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	GROUP A14 - HEALTH ASSESSMENTS
	HEALTH ASSESSMENTS Details of the requirements for health assessments are at A.24 – A.35 of the Explanatory Notes. The category of people eligible for health assessments are : a) Healthy Kids Check for children who have received or are receiving their four year old immunisation – A.25 b) People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool – A.26 c) People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease – A.27 d) People aged 75 years and older – A.28 e) Permanent residents of a Residential Aged Care Facility – A.29 f) People who have an intellectual disability – A.30 g) Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants – A.31
New **701**	**HEALTH ASSESSMENT - BRIEF** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a brief health assessment, lasting of not more than thirty 30 minutes duration and, including: a) Collection of relevant information, including taking a patient history; b) A basic physical examination; c) Initiating interventions and referrals as indicated; and d) Providing the patient with preventive health care advice and information. *(See para A24 of explanatory notes to this Category)* **Fee:** $55.00 **Benefit:** 100% = $55.00
New **703**	**HEALTH ASSESSMENT - STANDARD** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: a) Detailed information collection, including taking a patient history; b) An extensive physical examination; c) Initiating interventions and referrals as indicated; and d) Providing a preventive health care strategy for the patient. *(See para A24 of explanatory notes to this Category)* **Fee:** $127.80 **Benefit:** 100% = $127.80
New **705**	**HEALTH ASSESSMENT - LONG** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition and physical function; c) Initiating interventions and referrals as indicated; and d) Providing a basic preventive health care management plan for the patient. *(See para A24 of explanatory notes to this Category)* **Fee:** $176.30 **Benefit:** 100% = $176.30

New **707**	**HEALTH ASSESSMENT - PROLONGED** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a prolonged health assessment, lasting at least 60 minutes, including: a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition, and physical, psychological and social function. c) Initiating interventions and referrals as indicated; and d) Providing a comprehensive preventive health care management plan for the patient. *(See para A24 of explanatory notes to this Category)* **Fee:** $249.10 **Benefit:** 100% = $249.10
	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT Details of the requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment are at A.32-A.35 of the Explanatory Notes, The Aboriginal and Torres Strait Islander Peoples Health Assessment is available to: a) Children between ages of 0 and 14 years – A.33 b) Adults between the ages of 15 and 54 years – A.34 c) Older people over the age of 55 years – A.35
New **715**	**ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent – not more than once in a 9 month period. *(See para A32 of explanatory notes to this Category)* **Fee:** $196.65 **Benefit:** 100% = $196.65

CHRONIC DISEASE MANAGEMENT	CHRONIC DISEASE MANAGEMENT
	GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS
	SUBGROUP 1 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
Amend **721**	~~PREPARATION by~~ Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) for the PREPARATION of a **GP MANAGEMENT PLAN** (GPMP) for a patient (not being a service associated with a service to which **items ~~734 to 778~~ 735 to 758** apply). This CDM service is for a patient who has at least one medical condition that: (a) has been (or is likely to be) present for at least six months; or (b) is terminal. A rebate will not be paid within twelve months of a previous claim for ~~the same~~ item 721, or within three months of a claim for items ~~725,727,~~729, 731 or ~~731~~ 732 (for a review of a GPMP), except where there ~~has been a significant change in the patient's clinical condition or care cirmcumstances~~ are exceptional circumstances that ~~requires~~ require the preparation of a new ~~GP Management Plan~~ GPMP. *(See para ~~A33~~ A36 of explanatory notes to this Category)* **Fee:** $133.65 **Benefit:** 75% = $100.25 100% = $133.65
Amend **723**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **COORDINATE** the development of **TEAM CARE ARRANGEMENTS** (TCAs) for a patient (not being a service associated with a service to which **items ~~734 to 779~~ 735 to 758** apply). This CDM service is for a patient who: (a) has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal; and (b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. A rebate will not be paid within twelve months of a previous claim for ~~the same~~ item 723, or within three months of a claim for item ~~727~~ 732 (for a review of TCAs), except where there ~~has been a significant change in the patient's clinical condition or care~~ are exceptional circumstances that ~~requires~~ require the coordination of new ~~Team Care Arrangements~~ TCAs. *(See para ~~A33~~ A36 of explanatory notes to this Category)* **Fee:** $105.90 **Benefit:** 75% = $79.45100% = $105.90

Amend **729**	**CONTRIBUTION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) ~~to a multidisciplinary care plan~~ TO A MULTIDISCIPLINARY CARE PLAN prepared by another provider ~~or to a review of a multidisciplinary care plan~~ OR TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN prepared by another provider (not being a service associated with a service to which **items ~~734 to 779~~ 735 to 758** apply). This CDM service is for a patient who: (a) has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal; and (b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (c) is not a care recipient in a residential aged care facility. A rebate will not be paid within twelve months of a claim by the same practitioner for item 721 or 723, within three months of a claim for ~~the same~~ item 729 or within three months of a claim for item ~~725, item 727, or item 731~~ 731 or 732, except where there ~~has been a significant change in the patient's clinical condition or care~~ are exceptional circumstances that ~~requires~~ require a new contribution to the multidisciplinary care plan. *(See para ~~A33~~ A36 of explanatory notes to this Category)* **Fee:** $65.20 **Benefit:** 100% = $65.20
Amend **731**	**CONTRIBUTION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to~~:~~ ~~(a)~~ **a multidisciplinary care plan for a patient in ~~A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT IN~~ A RESIDENTIAL AGED CARE FACILITY (RACF)**, prepared by that facility, **or to a REVIEW of such a plan ~~OF SUCH A PLAN~~** prepared by ~~such a facility~~ a RACF; or (b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which **items ~~734 to 779~~ 735 to 758** apply). This CDM service is for a patient who: (a) has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal; and (b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (c) is a care recipient in a residential aged care facility. A rebate will not be paid within three months of a previous claim for ~~the same~~ item 731 or within three months of a claim for item 721, 723, ~~725, 727,~~ 729~~;~~ or 732 except where there ~~has been a significant change in the patient's clinical condition or care~~ are exceptional are exceptional circumstances that ~~requires~~ require a new contribution to the multidisciplinary care plan. *(See para ~~A33~~ A36 of explanatory notes to this Category)* **Fee:** $65.20 **Benefit:** 100% = $65.20

New **732**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to: (a) **REVIEW A GP MANAGEMENT PLAN** to which item 721 applies. Where these services were provided by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply. This CDM service is for a patient who has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal. or (b) **COORDINATE A REVIEW OF TEAM CARE ARRANGEMENTS** to which item 723 applies. This CDM service is for a patient who: i. has at least one medical condition that has been (or is likely to be) present for at least six months; or is terminal, and ii. also requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. Each service to which item 732 applies may only be claimed once in a three-month period, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient. **Fee:** $66.80 **Benefit:** 75% = $50.10100% = $66.80

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
	SUBGROUP 2 - CASE CONFERENCES **MULTIDISCIPLINARY CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)** These services are for patients who: (a) have at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal; and (b) require ongoing care from a multidisciplinary case conference team which includes: i. a medical practitioner; and ii. at least two other members, each of whom provides a different kind of care or service to the patient and is not a family carer of the patient, and one of whom may be another medical practitioner. For the purposes of items 735-758, a multidisciplinary case conference is a process by which a multidisciplinary case conference team: (a) discusses a patient's history; and (b) identifies the patient's multidisciplinary care needs; and (c) identifies outcomes to be achieved by members of the case conference team giving care and service to the patient; and (d) identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and (e) assesses whether previously identified outcomes (if any) have been achieved. Participation in a multidisciplinary case conference must be at the request of the person who organises and coordinates the conference.
New **735**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 15 minutes and less than 20 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $65.40 **Benefit:** 75% = $49.05100% = $65.40
New **739**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 20 minutes and less than 40 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $112.10 **Benefit:** 75% = $84.10100% = $112.10

New **743**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 40 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $186.85 **Benefit:** 75% = $140.15 100% = $186.85
New **747**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 15 minutes and less than 20 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $48.10 **Benefit:** 75% = $36.10100% = $48.10
New **750**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 20 minutes and less than 40 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $82.40 **Benefit:** 75% = $61.80100% = $82.40
New **758**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 40 minutes** **Fee:** $137.35 **Benefit:** 75% = $103.05 100% = $137.35

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	GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS
	SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN
	LEVEL A Professional attendance involving taking a short patient history and, if required, limited examination and management AND at which a cervical smear is taken from a woman at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999
Amend **2497**	~~**LEVEL A**~~ ~~Professional attendance involving taking a short patient history and, if required, limited examination and management~~ ~~AND at which a cervical smear is taken from a woman at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Fee:** $15.70 **Benefit:** 100% = $15.70
	LEVEL B Professional attendance by a general practitioner (not being a dervice to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND at which a cervical smear is taken from a woman at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years. Level B items cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.
Amend **2501**	~~Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which items 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies;~~ ~~AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994,10995,10998 or 10999.~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~ *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 100% = $34.30

Amend **2503**	**~~OUT-OF-SURGERY~~ CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~)~~ ~~This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.~~ *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2501, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $1.80 per patient.
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other iten is this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: f) taking a detailed patient history; g) performing a clinical examination; h) arranging any necessary investigation; i) implementing a management plan; j) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND at which a cervical smear is taken from a woman at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years. Level C items cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.
Amend Fee **2504**	**~~LEVEL 'C'~~** ~~Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;~~ ~~AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Fee:** ~~$65.20~~ $66.45 **Benefit:** 100% = ~~$65.20~~ $66.45
Amend **2506**	**~~OUT OF SURGERY~~ CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~). This item cannot be claimed in conjuction with items 10994,10995, 10998 or 10999.~~ *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2504, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $1.80 per patient.

	LEVEL D Professional attendance bya general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND at which a cervical smear is taken from a woman at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years. Level D items cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.
Amend Fee **2507**	~~**LEVEL 'D'**~~ ~~Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple sustems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;~~ ~~AND at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999.~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Fee:** ~~$95.95~~ $97.80 **Benefit:** 100% = ~~$95.95~~ $97.80
Amend **2509**	**~~OUT OF SURGERY~~ CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~).This item cannot be claimed in conjunction with items 10994,10995,10998 and 10999.~~ *(See para A5 and ~~A40~~ A43 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2507, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $1.80 per patient.

	SUBGROUP 2 - COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS The minimum requirements of care to complete an annual Diabetes Cycle of Care for patients with established diabetes mellitus must be completed over a period of at least 11 months and up to 13 months, and must include: - Assess diabetes control by measuring HbA1c — At least once every year - Ensure that a comprehensive eye examination is carried out* — At least once every two years - Measure weight and height and calculate BMI** — At least twice every cycle of care - Measure blood pressure — At least twice every cycle of care - Examine feet*** — At least twice every cycle of care - Measure total cholesterol, triglycerides and HDL cholesterol — At least once every year - Test for microalbuminuria — At least once every year - Provide self-care education — Patient education regarding diabetes management - Review diet — Reinforce information about appropriate dietary choices - Review levels of physical activity — Reinforce information about appropriate levels of physical activity - Check smoking status — Encourage cessation of smoking (if relevant) - Review of medication — Medication review * Not required if the patient is blind or does not have both eyes. ** Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight. *** Not required if the patient does not have both feet.
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus
Amend **2517**	~~**LEVEL 'B'**~~ ~~Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies;~~ ~~AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitis~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. ~~AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitis~~ *(See para A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 100% = $34.30

Amend **2518**	**~~OUT-OF-SURGERY~~CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~)~~. *(See para A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2517, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $1.80 per patient.
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following where clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
Amend Fee **2521**	**~~LEVEL 'C'~~** ~~Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and Implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which items 44, 47, 48, 50 or 51 applies;~~ ~~AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus~~ **~~SURGERY~~ CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Fee:** ~~$65.20~~ $66.45 **Benefit:** 100% = ~~$65.20~~ $66.45
Amend **2522**	**~~OUT-OF-SURGERY~~CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~)~~. ~~AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus~~ *(See para A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2521, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $1.80 per patient.

	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
Amend Fee **2525**	~~**LEVEL 'D'**~~ ~~**Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;**~~ ~~**AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus**~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Fee:** ~~$95.95~~ $97.80 **Benefit:** 100% = ~~$95.95~~ $97.80
Amend **2526**	~~**OUT-OF-SURGERY**~~**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~(~~Professional attendance at a place other than consulting rooms~~)~~. ~~**AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus**~~ *(See paras A5 and ~~A41~~ A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2525, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $1.80 per patient.

	SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE **Note: Benefits are payable for only one service included in Subgroup 3 or A19, Subgroup 3 in a 12-month period, unless a further Asthma Cycle of Care is clinically indicated**. At a minimum the Asthma Cycle of Care must include: - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient's use of and access to asthma related medication and devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) - provision of asthma self-management education to the patient - review of the written or documented asthma action plan.
	LEVEL B Professional attendance by a general practitioner (not being a dervice to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
Amend **2546**	~~Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36,37,38,40,43,44,47,48,50 or 51 applies;~~ ~~AND which completes the minimum requirements of the Asthma Cycle of Care.~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A42~~ A45 of explanatory notes to this Category)* **Fee:** $34.30 **Benefit:** 100% = $34.30
Amend **2547**	~~**OUT-OF-SURGERY**~~**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~AND which completes the minimum requirements of the Asthma Cycle of Care.~~ ~~(~~Professional attendance at a place other than consulting rooms~~)~~. *(See para A5 and ~~A42~~ A45 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2546, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $1.80 per patient.

	LEVEL C ~~Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44,47, 48, 50 or 51 applies;~~ Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, ~~involving~~ including any of the following ~~where~~ that are clinically relevant: a) taking a detailed patient history; b) ~~undertaking~~ performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to ~~one~~ 1 or more ~~health related~~ health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
Amend Fee **2552**	~~**LEVEL 'C'**~~ ~~Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44,47, 48, 50 or 51 applies;~~ ~~AND which completes the minimum requirements of the Asthama Cycle of Care.~~ ~~**SURGERY**~~**CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A42~~ A45 of explanatory notes to this Category)* **Fee:** ~~$65.20~~ $66.45 **Benefit:** 100% = ~~$65.20~~ $66.45

Amend **2553**	~~**OUT-OF-SURGERY**~~**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** ~~AND which completes the minimum requirements of the Asthma Cycle of Care.~~ ~~(~~Professional attendance at a place other than consulting rooms~~)~~. *(See para ~~A42~~ A45 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2552, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $1.80 per patient.
	LEVEL D Professional attendance lasting at least 40 minutes, involving any of the following where clinically relevant: a) taking an extensive history; b) undertaking a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
Amend Fee **2558**	~~Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;~~ ~~AND which completes the minimum requirements of the Asthama Cycle of Care.~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms~~)~~. *(See para A5 and ~~A42~~ A45 of explanatory notes to this Category)* **Fee:** ~~$95.95~~ $97.80 **Benefit:** 100% = ~~$95.95~~ $97.80
Amend **2559**	~~**OUT-OF-SURGERY**~~ **CONSULTATION AT A APLACE OTHER THAN CONSULTING ROOMS** ~~AND which completes the minimum requirements of the Asthama Cycle of Care.~~ ~~(~~Professional attendance at a place other than consulting rooms~~)~~. *(See para A5 and ~~A42~~ A45 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2558, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $1.80 per patient.

GENERAL PRACTITIONER	GENERAL PRACTITIONER
	GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	LEVEL A Professional attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Amend **5000**	~~**LEVEL A**~~ ~~Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $26.85 **Benefit:** 100% = $26.85
Amend **5003**	**HOME VISIT OR CONSULTATION AT AN INSTITUTION (OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY)** ~~(~~Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $1.80 per patient.
Amend **5010**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $3.10 per patient.
	LEVEL B Professional attendance by a general practitioner lasting less than 20 minutes, involving any of the following where clinically relevant: a) taking a history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.

Amend **5020**	~~**LEVEL 'B'**~~ ~~Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies~~ ~~**SURGERY**~~ **CONSULTATION** **AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.~~)~~ *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $45.45 **Benefit:** 100% = $45.45

Amend **5023**	**HOME VISIT OR CONSULTATION AT AN INSTITUTION (OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY)** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm 12noon on a Saturday, or before 8am or after 8pm 6pm on any other day.) *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $1.80 per patient.
Amend **5028**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm 12noon on a Saturday, or before 8am or after 8pm 6pm on any other day.) *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $3.10 per patient.
	LEVEL C Professional attendance by a general practitioner lasting at least 20 minutes, involving any of the following where clinically relevant: a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **5040**	~~**LEVEL 'C'**~~ ~~Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 5060, 5063, 5064 or 5067 applies~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** ~~$76.30~~ $77.75 **Benefit:** 100% = ~~$76.30~~ $77.75

Amend **5043**	**HOME VISIT OR CONSULTATION AT AN INSTITUTION (OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY)** ~~(~~Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital or residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $1.80 per patient.
Amend **5049**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $3.10 per patient.
	LEVEL D Professional attendance by a general practitioner lasting at least 40 minutes, involving any of the following where clinically relevant: a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Amend Fee **5060**	~~**LEVEL 'D'**~~ ~~Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan~~ ~~**SURGERY**~~ **CONSULTATION AT CONSULTING ROOMS** ~~(~~Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.~~)~~ *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** ~~$107.10~~ $109.15 **Benefit:** 100% = ~~$107.10~~ $109.15
Amend **5063**	**HOME VISIT OR CONSULTATION AT AN INSTITUTION (OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY)** ~~(~~Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital or residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $24.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $1.80 per patient.

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Amend **5067**	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** ~~(~~Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day.~~)~~ *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $3.10 per patient.

OTHER NON-REFERRED	OTHER NON-REFERRED
	GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	HOME VISIT OR CONSULTATION AT AN INSTITUTION (OTHER THAN A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY) Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms, a hospital or residential aged care facility.
Amend **5220**	~~**HOME VISITS**~~ ~~**(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)**~~ **BRIEF ~~HOME VISIT~~ CONSULTATION** in an after hours period of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient.
Amend **5223**	**STANDARD ~~HOME VISIT~~ CONSULTATION** in an after hours period of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient.
Amend **5227**	**LONG ~~HOME VISIT~~ CONSULTATION** in an after hours period of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient.
Amend **5228**	**PROLONGED ~~HOME VISIT~~ CONSULTATION** in an after hours period of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient.
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients on 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion – each patient.

Amend **5260**	~~**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY**~~ ~~(Professional attendance on 1 or more patients on 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) – each patient~~ **BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $1.25 per patient.
Amend **5263**	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $1.25 per patient.
Amend **5265**	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $1.25 per patient.
Amend **5267**	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after ~~1pm~~ 12noon on a Saturday, or before 8am or after ~~8pm~~ 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $1.25 per patient.

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Category 3 – Therapeutic Procedures

RADIATION ONCOLOGY	RADIATION ONCOLOGY
	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION
Amend **15700**	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) ~~– each non contiguous treatment site verified,~~ when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). *(See para T2.5 of explanatory notes to this Category)* **Fee:** $45.95 **Benefit:** 75% = $34.5085% = $39.10
Amend **15705**	RADIATION ONCOLOGY TREATMENT VERIFICATION – or volumetric multiple projection acquisition ~~– each non contiguous treatment site verified to a maximum of 3 sites per attendance~~, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). *(See para T2.5 of explanatory notes to this Category)* **Fee:** $76.60 **Benefit:** 75% = $57.4585% = $65.15
New **15710**	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 – each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para T2.5 of explanatory notes to this Category) **Fee:** $76.60 **Benefit:** 75% = $57.4585% = $65.15

BOTULINUM TOXIN INJECTIONS	BOTULINUM TOXIN INJECTIONS
	GROUP T11 - BOTULINUM TOXIN INJECTIONS
Amend **18354**	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient,aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, ~~between the ages of 2 and 17 (inclusive)~~, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $118.00 **Benefit:** 75% = $88.5085% = $100.30
Amend **18356**	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, ~~between the ages of 2 and 17 (inclusive)~~, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $118.00 **Benefit:** 75% = $88.5085% = $100.30
Amend **18358**	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, ~~between the ages of 2 and 17 (inclusive)~~, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $118.00 **Benefit:** 75% = $88.5085% = $100.30

OPERATIONS	GENERAL
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
Amend **30479**	~~ENDOSCOPIC~~ ENDOSCOPY with LASER THERAPY or ARGON PLASMA COAGULATION, for the treatment of neoplasia ~~and~~, benign vascular lesions ~~or~~, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (GAVE) or post-polypectomy bleeding, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $449.95 **Benefit:** 75% = $337.50 85% = $382.50
	SUBGROUP 2 - COLORECTAL
Amend **32087**	Endoscopic examination of the colon up to the hepatic flexure by FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY ~~up to the hepatic flexure WITH REMOVAL OF ONE OR MORE POLYPS for the REMOVAL OF 1 OR MORE POLYPS~~ for the REMOVAL OF 1 OR MORE POLYPS or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of, not being a service to which item 32078 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $193.45 **Benefit:** 75% = $145.10 85% = $164.45
Amend **32093**	Endoscopic examination of the colon beyond the hepatic flexure by FIBREOPTIC COLONOSCOPY ~~examination of colon beyond the hepatic flexure WITH REMOVAL OF ONE OR MORE POLYPS~~ for the REMOVAL OF 1 OR MORE POLYPS, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $443.40 **Benefit:** 75% = $332.55 85% = $376.90

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	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 5 - UROLOGICAL
	OPERATIONS ON BLADDER
New **36663**	Sacral nerve lead(s), percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $624.70 **Benefit:** 75% = $468.55
New **36664**	Sacral nerve lead(s), percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning) and intraoperative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older, not being a service associated with a service to which item 36663 applies (Anaes.) **Fee:** $561.00 **Benefit:** 75% = $420.75
New **36665**	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention – each day **Fee:** $118.50 **Benefit:** 75% = $88.9085% = $100.75
New **36666**	Pulse generator, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $315.60 **Benefit:** 75% = $236.70
New **36667**	Sacral nerve lead(s), removal of, if the lead was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $147.75 **Benefit:** 75% = $110.85
New **36668**	Pulse generator, removal of, if the pulse generator was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $147.75 **Benefit:** 75% = $110.85

Category 6 - Pathology

PATHOLOGY	PATHOLOGY
	GROUP P7 - GENETICS
Amend **73287**	~~Chromosome studies, (karyotype),~~The study of the whole of every chromosome by cytogenetic or other ~~comparable~~ techniques, ~~of~~ performed on 1 or more of any tissue or fluid except blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $397.20 **Benefit:** 75% = $297.90 85% = $337.65
Amend **73289**	~~Chromosome studies, (karyotype),~~The study of the whole of every chromosome by cytogenetic or other ~~comparable~~ techniques, ~~of~~ performed on blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $361.35 **Benefit:** 75% = $271.05 85% = $307.15
New **73290**	The study of the whole of each chromosome by cytogenetic or other techniques, performed on blood or bone marrow, in the diagnosis and monitoringof haematological malignancy (including a service in items 73287 or 73289, if performed). - 1 or more tests. **Fee:** $397.20 **Benefit:** 75% = $297.90 85% = $337.65
New **73291**	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in a) diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or b) studies of a relative for an abnormality previously identified in such an affected person. – 1 or more tests. **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $197.65
New **73292**	Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed) – 1 or more tests. **Fee:** $593.85 **Benefit:** 75% = $445.40 85% = $524.75
New **73293**	Analysis of one or more regions on all chromosomes for specific constitutional genetic abnormalities of fresh tissue in diagnostic studies of the products of conception, including exclusion of maternal cell contamination. – 1 or more tests. **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $197.65
New **73294**	Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as: a) diagnostic studies of an affected person; or b) studies of a relative for an abnormality previously identified in an affected person – 1 or more tests. **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $197.65

Category 8 – Miscellaneous

MISCELLANEOUS	MISCELLANEOUS
	GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER
New **10986**	Service provided by a practice nurse or registered Aboriginal health worker being the provision of a health assessment 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 701, 703, 705, 707. Benefits are payable on one occasion only for each eligible patient *(See para M12.1 of explanatory notes to this Category)* **Fee:** $55.00 **Benefit:** 100% = $55.00

	GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES
New **10985**	A medical service to which item 597, 598, 599 or 600 applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is not provided in consulting rooms; and (e) the service is provided in one of the following eligible areas; and: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan, Perth (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm (Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan, Perth (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) (f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and (g) the service is bulk billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service. **Fee:** $10.05 **Benefit:** 85% = $8.55

MISCELLANEOUS	MISCELLANEOUS
	GROUP M9 - ALLIED HEALTH GROUP SERVICES
Amend **81100**	**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~~ 732], 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 contains all the components of 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). *(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)* **Fee:** $75.45 **Benefit:** 85% = $64.15

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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~~ 732, 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 contains all the components of 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).

Amend

(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)

81110

Fee: $75.45 **Benefit:** 85% = $64.15

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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~~ 732], 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 contains all components of 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).

Amend

(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)

81120 **Fee:** $75.45 **Benefit:** 85% = $64.15

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MISCELLANEOUS	MISCELLANEOUS
	GROUP M11 - ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK
Amend **81300**	**ABORIGINAL ~~OR~~ AND TORRES STRAIT ISLANDER HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible Aboriginal health worker if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible Aboriginal health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of ~~5~~ five services (including services to which items 81300 to 81360 inclusive apply) in a calendar ye *(See para M11.1 of explanatory notes to this Category)* **Fee:** $58.85 **Benefit:** 85% = $50.05