Australian Government

Department of Health and Aged Care

Medicare Benefits Schedule Book

Category 1

Operating from 1 July 2024

Title: Medicare Benefits Schedule Book

At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

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

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GN.0.1 AskMBS Email Advice Service

If you are a patient seeking advice about Medicare services, benefits or your Medicare claims, please contact Services Australia on the Medicare general enquiry line - 132 011.

AskMBS responds to enquiries from providers of services listed on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health and Aged Care, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line on 13 21 50.

AskMBS issues advisories summarising responses to frequently asked questions on specific subject areas.
AskMBS Email Advice Service

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

Higher rates of benefits are provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

GN.1.2 Medicare - an outline

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Services Australia administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

a. Free treatment for public patients in public hospitals.
b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). The relevant benefit rates are:

i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients, or for general practitioner attendances specified as not being hospital treatments - see note below;
ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner*;
iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients), including services provided in hospital outpatient settings but not generally including services set out in the note below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient');
iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment such as ‘hospital in the home’, but generally not including certain services listed below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment';
v. 85% of the Schedule fee for all other services.

Note: while hospital treatments and hospital-substitute treatments attract a 75% rebate, most attendances, services provided to private patients in emergency departments, pathology services and diagnostic imaging services do not generally require hospital treatment and therefore do not attract a rebate of 75% of the Schedule fee unless certified as a 'Type C' treatment. A list of most MBS items in scope of this exception, and the requirements around certifying a treatment as 'Type C' can be found in the Private Health Insurance (Benefit Requirement) Rules 2011. Services provided to a private patient in an emergency department are exempted under the Private Health Insurance (Health Insurance Business) Rules 2018.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the Therapeutic Goods Act 1989.

Where a Medicare benefit has been inappropriately paid, Services Australia may request its return from the practitioner concerned.

* MBS items 10988 and 10989 generally attract a 100% rebate but can be specified as 'Type C' treatments and attract a 75% rebate.

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act

A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation - any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that Services Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Services Australia will take recovery action.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the Department of Health and Aged Care's website.

GN.2.4 Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with the Services Australia to provide these services.

GN.2.5 Provider Numbers

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply ***in writing*** to Services Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Services Australia website.

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and ***either*** the provider number for the location where the service was provided ***or*** the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health and Aged Care.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

GN.2.6 Locum tenens

Where a locum tenens will be in a practice for more than two weeks ***or*** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Services Australia (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

GN.2.7 Overseas trained doctor

Ten year moratorium

Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from either

a. their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973*; or
b. their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

a. registered with a State or Territory medical board and retained a continuing right to remain in Australia; or
b. lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

a. demonstrate that they need a provider number and that their employer supports their request; and
b. provide the following documentation:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

GN.2.8 Contact details for Services Australia

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Services Australia.

Changes to Provider Contact Details

It is important that you contact Services Australia promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to Services Australia at:

Medicare

GPO Box 9822

in your capital city

or

the Medicare Provider telephone line on 132 150.

You may also be able to update some provider details through HPOS http://www.servicesaustralia.gov.au/hpos

GN.3.9 Patient eligibility for Medicare services

This note sets out who can access Medicare services.

ELIGIBLE GROUPS

To be eligible for Medicare, a person must ordinarily live in Australia, be located in Australia at the time of the service, and be:

- an Australian citizen
- an Australian permanent resident
- a New Zealand citizen
- a Resident Return visa holder
- an applicant for permanent residency (conditions apply) or
- a temporary visa holder covered by a Ministerial Order.

Ministerial Orders made under Section 6(1) of the *Health Insurance Act 1973* grant eligibility to groups including Australian citizens who have been absent from Australia for up to five years and holders of particular temporary visa types.

Note: access to Medicare by visitors to Australia who are covered by a Reciprocal Health Care Agreement is subject to the specific conditions of each Agreement (see below).

ENROLLING IN MEDICARE

The patient must enrol with Medicare before receiving Medicare benefits. Once enrolled, they will receive a Medicare Card. There are three types of Medicare cards, in the following colours:

Green – this is the standard Medicare card for Australian citizens, permanent residents and New Zealand citizens living in Australia and Resident Return visa holders.

Blue – this is the card for people who have applied for permanent residence or who hold a temporary visa covered by a Ministerial Order.

Yellow – this is the card for visitors to Australia from a country with a Reciprocal Health Care Agreement.

More information about enrolling in Medicare and the different Medicare cards is available from Services Australia.

RECIPROCAL HEALTH CARE AGREEMENTS

Under Section 7 of the *Health Insurance Act 1973*, the Australian Government has agreements with 11 other governments to cover the cost of certain medical care when Australians and overseas residents visit each other's countries.

Eligible overseas visitors from these countries generally receive:

- inpatient/outpatient services as a public patient in a public hospital
- out of hospital care
- Pharmaceutical Benefits Scheme (PBS) prescription medicines

Exceptions: Visitors from New Zealand and Ireland are entitled to public hospital care and PBS drugs only (not MBS services).

Reciprocal Health Care Agreements do not cover the cost of treatment as a private patient in a public or private hospital.

People visiting Australia for the specific purpose of receiving medical treatment are not covered.

Eligible Countries:

As at 1 February 2024, Australia has Reciprocal Health Care Agreements with the following countries:

- Belgium
- Finland
- Italy (eligibility limited to six months from date of arrival)
- Malta (eligibility limited to six months from date of arrival)
- Netherlands
- New Zealand (public hospital care and PBS medicines only, not MBS services)
- Norway
- Ireland (public hospital care and PBS medicines only, not MBS services)
- Slovenia
- Sweden
- United Kingdom

Eligible patients from these countries need to enrol in Medicare to access MBS services. Once enrolled they will have a yellow Medicare card.

- Visitors from New Zealand and Ireland do not need to enrol in Medicare to access public hospital services and PBS medicines under the Reciprocal Health Care Agreements. They are not eligible for MBS services unless they hold a green Medicare card.

More information about access to medical care under each Reciprocal Health Care Agreement is available from Services Australia.

OTHER VISITORS AND TEMPORARY RESIDENTS

Other visitors and temporary residents are not eligible for Medicare and should arrange private health insurance cover.

RELEVANT LEGISLATION

Information about the legislative arrangements applying to Medicare and the Reciprocal Health Care Agreements is set out in the *Health Insurance Act 1973*, which can be found on the Federal Register of Legislation.

GN.4.13 Who can use the Medicare Benefits Schedule GP items?

SUMMARY

This general note sets out which medical practitioners can use the MBS general practitioner (GP) items.

Medical practitioners that are eligible to provide Medicare services who are not GPs but provide services in a general practice setting can use the medical practitioner and prescribed medical practitioner (explanatory note AN.7.1) MBS items.

WHO CAN USE THE MBS GP ITEMS?

The *Health Insurance Act 1973* (the Act), and legal instruments made under the Act, set out which medical practitioners can claim MBS GP items. The four categories of medical practitioner that can access MBS GP items are those that are:

1. Fellows of a General Practice College
2. On an approved placement in a general practice training program
3. Listed on the Vocational Register of GPs (closed to new participants)
4. Eligible non-VR GPs (closed to new participants)

Before you can claim MBS GP items you must have a Medicare provider number for the location at which you are practising. You can apply for a Medicare provider number through Services Australia.

1. Medical practitioners who are fellows of a General Practice College

Medical practitioners that are fellows of either the:

- Australian College of Rural and Remote Medicine (ACRRM), or
- Royal Australian College of GPs (RACGP)

are GPs for MBS purposes.

Services Australia uses the Australian Health Practitioner Regulation Agency (Ahpra) Register of Medical Practitioners to determine practitioners' access to the GP items. Fellows of the RACGP and ACRRM must hold specialist registration as a GP with the Medical Board of Australia to access the GP items. The Ahpra registration for these medical practitioners will indicate that they are a specialist in the field of general practice.

2. Medical practitioners on an Approved Placement in a general practice training program

Section 1.1.3 of the *Health Insurance (General Medical Services Table) Regulations 2021* provides access to the MBS GP items to medical practitioners undertaking an approved training placement. That is, a training placement that will lead to fellowship with the RACGP or ACCRM.

- For more information on approved training placements see the General Practice Fellowship Program Placement Guidelines.

Your placement organisation must advise Services Australia of the placement before MBS GP items can be accessed.

3. Medical practitioners on the Vocational Register of GPs

The Vocational Register of GPs closed to new participants on 16 June 2021.

Section 16 of the *Health Insurance Regulation 2018* allows medical practitioners whose names are entered onto the Vocational Register of GPs to access MBS GP items provided they continue to be registered with Ahpra.

4. Eligible non-vocationally recognised medical practitioners

The programs below closed to new participants on 1 January 2019.

Section 1.1.2 of the *Health Insurance (General Medical Services Table) Regulations 2021* specifies which non-vocationally recognised medical practitioners can access MBS GP items:

1. Medical practitioners who have been notified by the Chief Executive of Medicare that they have completed the requirements of the MedicarePlus for Other Medical Practitioners Program before 31 December 2023.

2. Participants in the Other Medical Practitioners Extension Program who were enrolled in one of the following programs as at 30 June 2023:
    a. After Hours Other Medical Practitioner Program
    b. Outer Metropolitan Other Medical Practitioner Program
    c. Rural Other Medical Practitioner Program

RELEVANT LEGISLATION

Details of the legislative arrangements applying to the categories of medical practitioners able to use the MBS GP items can be found on the Federal Register of Legislation, and are set out in three regulatory instruments:

- *Health Insurance Act 1973*
- *Health Insurance (General Medical Services Table) Regulations 2021*
- *Health Insurance Regulations 2018*

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

· is registered as a specialist under State or Territory law; or

· holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give Services Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare benefits. Specialist trainees should consult the information available at Services Australia's Medicare website.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at Services Australia Medicare website.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the Department of Health and Aged Care website.

GN.5.15 Emergency Medicine

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or

(b) suffering from suspected acute organ or system failure; or

(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

(d) suffering from a drug overdose, toxic substance or toxin effect; or

(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and

(h) treated in, or via, a bona fide emergency department in a hospital.

Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

GN.5.16 Conjoint Committee for recognising training in Micro Bypass Glaucoma Surgery (MBGS)

The Conjoint Committee comprises representatives from the Australian and New Zealand Glaucoma Society (ANZGS) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). For the purposes of MBS item 42504, specialists performing this procedure must have certification and training recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery, and Services Australia notified of that recognition.

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

For certain services provided by specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.6** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

What is a Referral?

A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i), (ii) and (iii) do not apply to

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 -17655) a referral is required.

Who can Refer?

The general practitioner is regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

Billing

Routine Referrals

In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(i) Lost, stolen or destroyed referrals.

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergencies

If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

Private Patients - Where a referral is generated during an episode of hospital treatment for a service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

Public Hospital Patients

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

Bulk Billing

Bulk billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

Period for which Referral is Valid

The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

Specialist Referrals

Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission and ceases when the patient is discharged.

A referral for a specialist professional service to a patient in a hospital who is not a public patient is valid until the patient ceases to be a patient in the hospital.

As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment

A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters

The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Services Australia CEO, to produce to a medical practitioner who is an employee of Services Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

Locum-tenens Arrangements

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Self Referral

Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

GN.7.17 Billing procedures

The Services Australia website contains information on Medicare billing and claiming options. Please visit the Services Australia website for further information.

Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable).

GN.8.18 Provision for review of individual health professionals

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Services Australia monitors health practitioners' claiming patterns. Where Services Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:

decide to take no further action; or

enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:

investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

hold hearings and require the person under review to attend and give evidence;

require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduce accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

an unusual occurrence;

the absence of other medical services for the practitioner's patients (having regard to the practice location); and

the characteristics of the patients.

(b) Sampling - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) Generic findings - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

GN.8.19 Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

GN.8.20 Referral of professional issues to regulatory and other bodies

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

GN.8.21 Comprehensive Management Framework for the MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

GN.8.22 Medical Services Advisory Committee

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website - www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 7550.

GN.8.23 Pathology Services Table Committee

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

GN.9.25 Penalties and Liabilities

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

GN.10.26 Schedule fees and Medicare benefits

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for

that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

a. 75% of the Schedule fee:
    i. for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments – see GN1.2;
    ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'. Certain services are not generally considered hospital treatments – see GN1.2.
b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner – see GN1.2 for exceptions.
c. 85% of the Schedule fee, or the Schedule fee less $98.70 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the 2020-2025 Addendum to the National Health Reform Agreement.

Where a Medicare item with multiple components is provided, and some components are provided in the hospital and the remainder outside of the hospital (e.g. aftercare), the 75% benefit level applies. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits if not a type of item specified in GN1.2 as not generally being a hospital treatment.

It should be noted that private health insurers can cover the "patient gap" (that is, the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patients may insure with private health insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

GN.10.27 Medicare Safety Nets

The Medicare Safety Nets provide families and individuals with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the Original Medicare Safety Net (OMSN) and the Extended Medicare Safety Net (EMSN).

Original Medicare Safety Net:

Under the OMSN, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2024 is $560.40. This threshold applies to all Medicare-eligible individuals and families.

Extended Medicare Safety Net:

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for up to 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2024, the threshold for concessional individuals and families, including families that received Family Tax Benefit Part (A), is $811.80. The threshold for all other (non-concessional) individuals and families in 2024 is $2544.30.

The thresholds for both safety nets are indexed on 1 January each year in line with the Consumer Price Index (CPI).

Individuals are automatically registered with Services Australia for the safety nets. Families (including couples) are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be completed online at https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor. Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. In other words, once the patient reaches the EMSN threshold, they will receive either 80% of their out-of-pocket costs back or the EMSN cap amount, whichever is the lower amount.

For example: Item A has a Schedule fee of $100, the out-of-hospital benefit is $85 (85% of the Schedule fee). The EMSN benefit cap is $30. Assuming that the patient has reached the EMSN threshold:

o If the fee charged by the doctor for Item A is $125, the standard Medicare rebate is $85, with an out-of-pocket cost of $40. The EMSN benefit is calculated as $40 x 80% = $32. However, as the EMSN benefit cap is $30, only $30 will be paid.

o If the fee charged by the doctor for Item A is $110, the standard Medicare rebate is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

GN.11.28 Services not listed in the MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line - 13 21 50.

If you have a query relating exclusively to interpretation of the Schedule, you should email mailto:askmbs@health.gov.au

GN.11.29 Ministerial Determinations

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

GN.12.30 Professional services

Professional services which attract Medicare benefits include medical services rendered by or "on behalf of" a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not essential assistance is provided, according to accepted medical practice:-

(a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11729, 11730, 11731, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14221 and 14245);

(d) Item 15600 in Group T2 (Radiation Oncology);

(e) All Group T3 (Therapeutic Nuclear Medicine) items;

(f) All Group T4 (Obstetrics) items (except 16400 and 16514);

(g) All Group T6 (Anaesthetics) items;

(h) All Group T7 (Regional or Field Nerve Block) items;

(i) All Group T8 (Operations) items;

(j) All Group T9 (Assistance at Operations) items;

(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty where the patient is referred by another medical practitioner.

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

(a) the medical practitioner in whose name the service is being claimed;

(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

(a) established consistent quality assurance procedures for the data acquisition; and

(b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on the medical practitioner's own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 2

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 3

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the *Health Insurance Act 1973*. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

GN.13.33 Services which do not attract Medicare benefits

Medical services that do not attract Medicare benefits

(a) issue of repeat prescriptions when the patient does not attend the surgery in person;

(b) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(c) non-therapeutic cosmetic surgery;

(d) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable where the medical expenses for the service

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;

(d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the service is a health screening service.

(e) the service is a pre-employment screening service

Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;

(b) the injection of human chorionic gonadotrophin in the management of obesity;

(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the removal of tattoos;

(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

(f) the removal from a cadaver of kidneys for transplantation;

(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

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

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below:

(a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

(j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain;

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;

(o) extracorporeal magnetic innervation.

Health Screening Services

Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

(a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

The National Policy for the National Cervical Screening Program (NCSP) is as follows:

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

GN.14.35 Services attracting benefits on an attendance basis

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis.

GN.14.36 Consultation and procedures rendered at the one attendance

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

GN.14.37 Aggregate items

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

GN.14.38 Residential aged care facility

A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

GN.15.39 Practitioners should maintain adequate and contemporaneous records

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the Department of Health and Aged Care's website.

CATEGORY 1: PROFESSIONAL ATTENDANCES

SUMMARY OF CHANGES FROM 01/07/2024

The 01/07/2024 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Deleted Items

93716 93717

Description Amended

111 115 117 120 177 90001 90002 92173

Fee Amended

3	4	23	24	36	37	44	47	104	105	106	107	108
109	110	111	115	116	117	119	120	122	123	124	128	131
132	133	135	137	139	141	143	145	147	160	161	162	163
164	170	171	172	177	179	181	185	187	189	191	193	195
197	199	203	206	214	215	218	219	220	221	222	223	224
225	226	227	228	229	230	231	232	233	235	236	237	238
239	240	243	244	245	249	272	276	277	279	281	282	283
285	286	287	289	291	293	294	296	297	299	300	301	302
303	304	306	308	309	310	311	312	313	314	315	316	318
319	320	322	324	326	328	330	332	334	336	338	341	342
343	344	345	346	347	349	385	386	387	388	410	411	412
413	414	415	416	417	585	588	591	594	599	600	699	701
703	705	707	715	721	723	729	731	732	733	735	737	739
741	743	745	747	750	758	761	763	766	769	772	776	788
789	792	820	822	823	825	826	828	830	832	834	835	837
838	855	857	858	861	864	866	871	872	880	900	903	930
933	935	937	943	945	946	948	959	961	962	964	969	971
972	973	975	986	2197	2198	2200	2700	2701	2712	2713	2715	2717
2721	2723	2725	2727	2739	2741	2743	2745	2801	2806	2814	2824	2832
2840	2946	2949	2954	2958	2972	2974	2978	2984	2988	2992	2996	3000
3005	3010	3014	3018	3023	3028	3032	3040	3044	3051	3055	3062	3069
3074	3078	3083	3088	3093	4001	5000	5001	5003	5004	5010	5011	5012
5013	5014	5016	5017	5019	5020	5021	5022	5023	5027	5028	5030	5031
5032	5033	5035	5036	5039	5040	5041	5042	5043	5044	5049	5060	5063
5067	5071	5076	5077	6007	6009	6011	6013	6015	6018	6019	6023	6024
6028	6029	6031	6032	6034	6035	6037	6038	6042	6051	6052	6057	6058
6062	6063	6064	6065	6067	6068	6071	6072	6074	6075	6080	6081	6082
6084	10660	10661	10801	10802	10803	10804	10805	10806	10807	10808	10809	10816
10905	10907	10910	10911	10912	10913	10914	10915	10916	10918	10921	10922	10923
10924	10925	10926	10927	10928	10929	10930	10931	10932	10933	10940	10941	10942
10943	10944	10945	10946	90001	90002	90005	90020	90035	90043	90051	90054	90183
90188	90202	90212	90215	90250	90251	90252	90253	90254	90255	90256	90257	90260
90261	90264	90265	90266	90267	90271	90272	90273	90274	90275	90276	90277	90278
90300	91790	91794	91800	91801	91802	91806	91807	91808	91818	91819	91820	91821
91822	91823	91824	91825	91826	91827	91828	91829	91830	91831	91833	91836	91837
91838	91839	91842	91843	91844	91845	91859	91861	91862	91863	91864	91865	91866
91867	91868	91869	91870	91871	91872	91873	91874	91875	91876	91877	91878	91879
91880	91881	91882	91883	91884	91890	91891	91900	91906	91910	91916	91920	91926
92004	92011	92024	92025	92026	92027	92028	92055	92056	92057	92058	92059	92112

92113	92114	92115	92116	92117	92118	92119	92120	92121	92122	92123	92126	92127
92132	92133	92136	92137	92138	92139	92140	92141	92142	92146	92147	92148	92149
92150	92151	92152	92153	92162	92163	92170	92171	92172	92173	92176	92177	92182
92184	92186	92188	92194	92196	92198	92200	92210	92211	92422	92423	92434	92435
92436	92437	92455	92456	92457	92513	92514	92515	92516	92521	92522	92610	92611
92612	92613	92614	92618	92623	92624	92701	92715	92717	92718	92720	92721	92723
92724	92726	92731	92733	92734	92736	92737	92739	92740	92742	93644	93645	93646
93647	93653	93654	93655	93656	93660	93661						

Indexation

From 1 July 2024, annual fee indexation will be applied to most of the general medical services items. The MBS indexation factor for 1 July 2024 is 3.5 per cent.

Amendment to telehealth item 92173

From 1 July 2024, telehealth item 92173 will be amended to align the attendance duration time with face-to-face equivalent item 90267.

Expiration of long consult telephone attendance items for anti-viral assessment

Items 93716 and 93717 will be deleted in line with their 30 June 2024 cessation date.

Administrative amendments

From 1 July 2024, administrative amendments will be made to items 111, 115, 117, 120 and 177 to align the item descriptors with relevant legislation.

PROFESSIONAL ATTENDANCES NOTES

AN.0.1 Personal Attendance by Practitioner

The personal attendance of the medical practitioner upon the patient is necessary, before a "consultation" may be regarded as a professional attendance. In itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted. Periods such as when a patient is resting between blood pressure readings, waiting for pupils to dilate after the instillation of a mydriatic, or receiving short wave therapy etc., should not be included in the time of the consultation. Similarly, the time taken by a doctor to travel to a patient's home should not be taken into consideration in the determination of the length of the consultation. While the doctor is free to charge a fee for "travel time" when patients are seen away from the surgery, benefits are payable only in respect of the time a patient is receiving active attention.

AN.0.2 Benefits For Services

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services by optometrists. The *Health Insurance Act 1973* contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health and Aged Care. Services Australia is responsible for consideration of applications and for the day to day operation of Medicare and the payment of benefits. Contact details of the Department of Health and Aged Care and Services Australia are located at the end of these Notes.

AN.0.3 Professional Attendances

Professional attendances by medical practitioners cover consultations during which the practitioner: evaluates the patient's health-related issue or issues, using certain health screening services if applicable; formulates a management plan in relation to one or more health-related issues for the patient; provides advice to the patient and/or relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient. (See the General Explanatory Notes for more information on health screening services.)

AN.0.4 Provider Numbers

To ensure that benefits are paid only for services provided by optometrists registered with the Optometry Board of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to registered optometrists. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to enable claims for Medicare benefits to be processed. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

Optometrists can obtain a provider number from Services Australia. A separate provider number is issued for each location at which an optometrist practises and has current registration. Provider numbers for additional practice locations may also be obtained from Services Australia following confirmation of registration. Optometrists cannot use another optometrist's provider number.

Locum Tenens

An optometrist who has signed an Undertaking and is to provide services at a practice location as a locum for more than two weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than two weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed an Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

· Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.

· Complete the Schedule which is available on the Services Australia website https://www.servicesaustralia.gov.au/, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party, for example the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on bulk-bill stationery.

AN.0.5 Services not Attracting Medicare Benefits

Letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (Note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.0.7 Multiple Attendances on the Same Day

Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same medical practitioner the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the assessment of benefits.

In some circumstances a subsequent attendance on the same day constitutes a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then some time later an eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples of single attendances are skin sensitivity testing, and when a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

AN.0.8 Benefits For Optometrists

What services are covered?

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services .The professional services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to a consultation on ocular or vision problems or related procedures. *The Health Insurance Act 1973* defines a 'clinically relevant service' as a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

From 1 January 2015, optometrists will be free to set their own fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account. A non-clinically relevant service must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare. Where it is necessary for the optometrist to seek patient information from Services Australia in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:

(a) the patient is advised of the need to seek the information and the reason the information is required;

(b) the patient's informed consent to the release of information has been obtained; and

(c) the patient's records verify the patient's consent to the release of information.

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;

(b) a significant consultation or examination procedure has been carried out;

(c) the service has been performed at premises to which the Undertaking relates;

(d) the service has involved the personal attendance of both the patient and the optometrist; and

(e) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

(a) delivery, dispensing, adjustment or repairs of visual aids;

(b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery;

(b) refractive surgery;

(c) tests for fitness to undertake sporting, leisure or vocational activities;

(d) compulsory examinations or tests to obtain any commercial licence (e.g. flying or driving);

(e) entrance to schools or other educational facilities;

(f) compulsory examinations for admissions to aged care facilities;

(g) vision screening.

Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;

(b) an attendance on behalf of teaching institutions on patients of supervised students of optometry;

(c) where the service is not "clinically relevant" (as defined in the *Health Insurance Act 1973).*

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or

(b) the service was rendered in one or more of the following circumstances -

(i) the employer arranges or requests the consultation

(ii) the results are provided to the employer by the optometrist

(iii) the employer requires that the employee have their eyes examined

(iv) the account for the consultation is sent to the employer

(v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's

workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to the optometrist's employer or practice partner or any dependants of that employer or partner.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

a ***spouse***, in relation to a dependant person means:

(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

(b) a de facto spouse of that person.

a ***child***, in relation to a dependant person means:

(a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

(b) a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the *Social Security Act 1991*; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

AN.0.9 Using time-tiered professional (general) attendance items

SUMMARY

This note sets out the key common principles that apply when using the time-tiered professional attendance (also referred to as general attendance, time-tiered attendance, and Level A-E attendance) MBS items for general practitioners (GPs), medical practitioners (who are not GPs) and prescribed medical practitioners (i.e. medical practitioners who are not GPs, specialists or consultant physicians). These items are usually claimed in a general practice setting.

Unless otherwise stated these principles apply to all general attendance items, regardless of location (in consulting rooms, out of consulting rooms or residential aged care facilities), time (business or after-hours), or mode (face to face or telehealth). For some categories of attendances (e.g. telehealth) additional requirements may apply.

Note: that within the general practice context, prescribed medical practitioners and medical practitioners who are not GPs are sometimes referred to as Other Medical Practitioners (OMPs) or non-vocationally registered (non-VR) GPs. References to OMPs in this Explanatory Note include both prescribed medical practitioners and medical practitioners who are not GPs.

Information on the definition of a GP for Medicare purposes is available in GN.4.13 and prescribed medical practitioners in AN.7.1.

Tables setting out the item numbers for the various time-tiers and locations, times of day and modes are available in Note AN.0.74 for GPs, and AN.7.2 for OMPs.

USE OF THE ITEMS

General attendance items are claimed for a professional attendance when no other MBS item applies. It is a general principle of the MBS that the item that best describes the service is the item that should be claimed. This means that where a more specific MBS items exists (for example a skin biopsy under MBS item 30071), the more specific item should be claimed. If no other MBS item accurately reflects the service provided, and the requirements of a general attendance item are met, the general attendance item is claimed.

General attendance items generally require that the medical practitioner attends the patient and does *at least* one of the following:

- taking a patient history
- performing a clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventive health care.

Appropriate and contemporaneous records must be kept.

The time-tiers range from Level A short consultation for straightforward tasks to 60+ minute Level E consultations.

General attendance items are both professional and personal attendances.

What is a professional attendance?

The Regulations state that a professional attendance includes the "*provision, for a patient, of any of the following services:*

- *evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the [Health Insurance] Act*
- *formulating a plan for the management and, if applicable, for the treatment of the patient's condition or conditions*
- *giving advice to the patient about the patient's condition or conditions and, if applicable, about treatment*
- *if authorised by the patient—giving advice to another person, or other persons, about the patient's condition or conditions and, if applicable, about treatment*
- *providing appropriate preventive health care*
- *recording the clinical details of the service or services provided to the patient."*

Further information on professional attendances is at AN.0.3.

What is a personal attendance?

The Regulations specify that personal attendance items *"apply to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion."* This means that:

- the patient must be present and only time spent with the patient counts towards the attendance
- another health practitioner (e.g. a practice nurse) cannot provide the service on behalf of a medical practitioner
- benefits are not payable if more than one medical practitioner provides an attendance on the same patient at the same time.

In the case of telehealth (video) and telephone attendances this requirement is modified to be "a service that is an attendance by a single health professional on a single person".

A guide on substantiating a patient's attendance is available on the Department of Health and Aged Care's website.

Further information on personal attendances is at AN.0.1.

How do I choose which general attendance item to use?

The correct general attendance item will depend on:

- practitioner type – GP, medical practitioner (excluding GPs) or prescribed medical practitioner
- length of time spent with the patient (i.e. the personal attendance time)
- location of the consultation – in consulting rooms, out of consulting rooms or residential aged care facility
- time of the consulting – business or after-hours
- mode of the consultation – face to face, telephone or telehealth (video), and
- for prescribed medical practitioners only – the location (by Modified Monash area) of the practice.

Reference tables setting out the relevant general attendance items are available at AN.0.74 for GPs and AN.7.2 for OMPs.

Can I address more than one issue in a general attendance?

Yes. All general attendance items can be claimed to address multiple issues with a patient.

When multiple issues are addressed in a single consultation, and more specific MBS items do not apply for any of these issues, medical practitioners should use the appropriate MBS general attendance item for the total time of the consultation. In these circumstances, medical practitioners should not claim each issue as a separate attendance.

What activities count towards the consultation time?

Only time spent with the patient (or on the telephone/video call with the patient in the case of telehealth) performing clinically relevant tasks can be included in the consultation time. Clinically relevant tasks include, but are not limited to:

- undertaking any of the activities described in the item descriptor
- communicating with the patient (and where relevant their carer)
- writing clinical notes, prescriptions or referrals, completing forms, reports or other paperwork relating to the patient while the patient is present
- reviewing, creating or updating entries in the patient's My Health Record while the patient is present.

Time taken to write clinical notes, complete forms, reports or other paperwork, upload records in My Health Record (or other systems), or talk to carers or relatives when the patient is not present cannot be included in the consultation time.

If the patient has particular needs that mean good communication takes longer than average can this time be included?

Yes, communicating effectively with patients is crucial to achieving clinical outcomes and a key part of a clinical service. A wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service. This applies to both face to face and telehealth services.

In such situations, medical practitioners and other providers should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

Can I provide another medical service that is not a general attendance (e.g. a procedure or diagnostic test) and a general attendance to the same patient on the same day?

In general, yes. However, there are some limitations including:

- both services must be clinically relevant and distinct services
- the other item must not have restrictions on same day claiming as a general attendance item, and
- the other item is not listed in MBS Group T6 (Anaesthetics) or T9 (Assistance at Operation).

Where more than one service is provided to a patient on the same day, the time taken for the second service (e.g. a procedure) must not be included in the consultation time for the general attendance.

Procedural items include all necessary components required to provide the service. This would include obtaining informed procedural and financial consent, the procedure itself, a discussion of the results of the procedure and (unless stated otherwise) the provision of routine aftercare.

Where the results of a procedure inform a further consultation on management, the consultation may be eligible for a Medicare benefit.

Can I provide more than one general attendance service to the same patient on the same day?

Yes, provided that the subsequent attendance is not a continuation of the first attendance, both services are clinically relevant and distinct, and the item requirements are met for both attendances. Further information is available in AN.0.7.

Are there specific requirements for any of the general attendance items?

Yes, several general attendance items have additional, specific requirements:

- Telephone and telehealth (video) – patients can only access these services through their "usual medical practitioner" with limited exemptions. See AN.1.1 for further information. Some longer telephone items also require the patient to be registered with MyMedicare and can only be claimed at their registered practice.
- After-hours attendance items – can only be claimed in specific time periods. See AN.0.19 (GPs) and AN.7.24 (OMPs) for further information.
- Out of consulting rooms attendance items – have derived fee structures that vary with the number of patients attended or, in the case of some residential aged care facilities items, may be co-claimed with a flag fall item. See AN.0.11 (derived fees) and AN.35.1 and AN.35.2 (flag falls) for further information.
- Residential aged care facility items – See AN.0.15, AN.35.1 and AN.35.2 for further information.
- Items 179, 185, 189, 203, 301, 91906, 91916, 19794, 91806, 91807, 91808, 91926 – can only be claimed when the service is provided at a practice located in a Modified Monash 2-7 area. Practice locations can be checked on the Health Workforce Locator.

Can I claim a general attendance for providing aftercare?

No, you cannot claim a general attendance item if you performed the procedure that resulted in the need for aftercare.

However, the Health Insurance (Subsection 3(5) General Practitioner Post-Operative Treatment) Direction 2017 allows a medical practitioner working in general practice to use a general attendance item to provide aftercare provided that they did not perform the initial service that caused the need for aftercare. See AN.0.71 for further information.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits is eligible for face to face (in consulting rooms and out of consulting rooms) general attendance items (business hours or after-hours).

Residential aged care facility-specific items are only available to Medicare-eligible patients that are residents of a residential aged care facility.

Patients must meet the "usual medical practitioner" requirement to access telehealth (video) and telephone items, unless an exemption applies (see AN.1.1 for more information). In the case of telephone items 91900, 91903, 91906, 91910, 91913, 91916, the patient must also be registered with the practice providing the service through MyMedicare.

ELIGIBLE PRACTITIONERS

General attendance items are available for different practitioner types:

- general practitioner items can be claimed by general practitioners only (see GN.4.13).
- medical practitioner items can be claimed by any medical practitioner that is not explicitly excluded in the relevant item descriptor.
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a general attendance item and another item both services must be clinically relevant and distinct services.

General attendance items and chronic disease management items 229, 230, 233, 721, 723 and 732 *cannot* be claimed on the same day for the same patient. This restriction is set out in clause 2.16.11 of the Health Insurance (General Medical Services Table) Regulations 2021.
Further information on co-claiming of general attendance items and other MBS items is available in the AskMBS Advisory – General Practice Services #2.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Attendance items are set out in three regulatory instruments:

- *Health Insurance (Section 3C General Medical Service – Other Medical Practitioner) Determination 2018* – items 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 2197, 2198, 2200
- *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* – telehealth (video) and telephone attendance items.

- *Health Insurance (General Medical Services Table) Regulations 2021* – all other attendance items.

AN.0.11 Derived fee items for general practice

Derived fees apply to a range of attendance items that are used when services are provided outside of consulting rooms, including some MBS items used in residential aged care facilities.

An item is a derived fee item if the MBS benefit payable depends on the number of patients that are seen at the location. Not all out of consulting rooms items are derived fee items. Some out of consulting rooms items attract a flag fall, instead of using a derived fee. See AN.35.1, AN.35.2 and AN.44.1 for further information on flag falls.

To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion at one location, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one facility on the one occasion, each account, receipt or assignment form would show "Item 4 - 1 of 10 patients" for a general practitioner.

The number of patients seen should not include attendances which do not attract a Medicare rebate (e.g. public in-patients, attendances for normal after-care), or where a Medicare rebate is payable under an item other than these derived fee items (e.g. health assessments, care planning, emergency after-hours attendance - first patient).

AN.0.12 Billing Procedures

There are three ways benefits may be paid for optometric services:

(a) the claimant may pay the optometrist's account in full and then claim benefits from Services Australia by submitting the account and the receipt;

(b) the claimant may submit the unpaid account to Services Australia who will then send a cheque in favour of the optometrist, to the claimant; or

(c) the optometrist may direct-bill Medicare instead of the patient for the consultation. This is known as bulk billing. If an optometrist direct-bills, they undertake to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Claiming of benefits

The patient, upon receipt of an optometrist's account, has two options open for paying the account and receiving benefits.

Paid accounts

If the account has been paid in full a claimant can claim Medicare benefits in a number of ways:

- Electronically if the claimant's doctor offers this service and the claimant has completed and lodged bank account details with Medicare.
- Online through Medicare Online Services.
- At the claimant's local Services Australia Service Centre.
- By mail by sending a completed Medicare claim form (MS014) with the original accounts and/or receipts to:

Services Australia

Medicare

GPO Box 9822

In the claimant's capital city

- Over the phone by calling 132 011 and giving the claim details and then sending the accounts and/or receipts to:

Telephone Claiming

Services Australia

Medicare

GPO Box 9847

In the claimant's capital city

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at Services Australia's website.

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to Services Australia with a completed Medicare Claim form (MS014). In this case Services Australia will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist" cheques involving Medicare benefits must (by law), not be sent direct to optometrists, or to the claimant at an optometrist's address (even if requested by the claimant to do so). "Pay optometrist" cheques are required to be forwarded to the claimant's last known address as recorded with Services Australia.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist" cheque the optometrist should indicate on the receipt that a "Medicare cheque for $..... was involved in the payment of the account". The receipt should also include any money paid by the claimant or patient.

Itemised accounts

When an optometrist bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable the patient to claim Medicare benefits. Where both a consultation and another service, for example computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are only payable in respect of optometric services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:

(a) patient's name;

(b) date on which the service(s) was rendered;

(c) a description of the service(s) (e.g. "initial consultation," "subsequent consultation" or "contact lens consultation" and/or "computerised perimetry" in those cases where it is performed);

(d) Medicare Benefits Schedule item number(s);

(e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;

(f) the fee charged for the service(s); and

(g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment of benefit forms.

Details of any charges made other than for services, e.g. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (bulk billed) arrangements

Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If an optometrist bulk-bills, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

· the patient's Medicare number must be quoted on all bulk-bill assignment of benefit forms for that patient;

· the forms include information required by Regulations under Section 19(6) of the *Health Insurance Act 1973*; and

· the optometrist must cause the particulars relating to the professional service to be set out on the assignment of benefit form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment of benefit form, the signature of the patient's parent, guardian or other responsible person (other than the optometrist, optometrist's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical

condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk-billing

Where a patient presents without a Medicare card and indicates that they have been issued with a card but does not know the details, the optometrist may contact Services Australia on 132 150 to obtain the number.

It is important for the optometrist to check the eligibility of their patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

Only the approved assignment of benefit forms available from Services Australia's website, can be used to bulk-bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It includes a Medicare copy, a Practitioner copy and a Patient copy.

(b) **Form DB4**
This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

(c) **Forms DB4E**
Use this form to claim assigned benefits for electronically transmitted claims.
These services can be claimed through HPOS Bulk Bill Webclaim capability.
This form is interactive. It has 2 copies, one for the health professional and one for the patient.

(d) **Forms DB020**
Use this form in conjunction with HPOS Medicare Bulk Bill Webclaims only. It cannot be submitted to Services Australia for manual processing.
This form is interactive. It has 2 copies, one for the health professional and one for the patient.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Optometrists who accept assigned benefits must claim from Services Australia using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to an optometrist other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link for the principal optometrist's practice is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment of benefit forms to which the claim relates.

Time limits applicable to lodgement of bulk bill claims for benefits

A time limit of two years applies to the lodgement of claims with Services Australia under the bulk billed (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Services Australia.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the Services Australia website or the processing centre to which bulk-bill claims are directed.

AN.0.13 Attendances at a Hospital (Items 4, 24, 37, 47, 124, 58, 59, 60, 65, 165)

These items refer to attendances on patients admitted to a hospital. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, items for services provided in consulting rooms would apply.

AN.0.14 Referrals (Read in Connection with the Relevant Paragraphs at O.6)

General

Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the non-referred attendance rate, which has a lower rebate..

Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See relevant paragraph regarding emergency situations.

What is a referral?

For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place:

(a) the referring optometrist must have turned their mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);

(b) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

(c) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in the above paragraph are that:

(a) sub-paragraphs (b) and (c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and

(b) sub-paragraph (c) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

A referral from an optometrist to an ophthalmologist is valid for twelve months unless the optometrist specifies on the referral that the referral is for a different period (e.g. three, six or eighteen months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for twelve months from the date of the first service provided by the ophthalmologist.

Referrals for longer than twelve months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and

(c) the patient was last seen by the specialist ophthalmologist more than nine months earlier than the attendance following a new referral.

Self referral

Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Lost, stolen or destroyed referrals

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate, a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

Emergency situations

Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the *Health Insurance Regulations 2018*). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form as an "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

AN.0.15 After hours Residential Aged Care Facility Attendances (Items 772, 776, 788, 789, 2200, 5010, 5028, 5049, 5067, 5077, 5260, 5262, 5263, 5265, 5267)

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

Where a medical practitioner attends a patient in a self-contained unit, within a residential aged care facility complex, the attendance attracts benefits under the appropriate home visit item.

Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the residential aged care facility, or at free standing consulting rooms within the residential aged care facility complex, the appropriate surgery consultation item applies.

If a patient who is accommodated in the residential aged care facility visits a medical practitioner at consulting rooms situated within the residential aged care facility complex, whether free standing or situated within the residential aged care facility precincts, benefits would be attracted under the appropriate residential aged care facility attendance item.

To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where two patients were visited (for a brief consultation) in the one facility on the one occasion, each account, receipt or assignment form would show "Item 5010 - 1 of 2 patients" for a general practitioner.

The number of patients seen should not include attendances which do not attract a Medicare rebate (e.g. public in-patients, attendances for normal after-care), or where a Medicare rebate is payable under an item other than these derived fee items (e.g. items that attract a flag fall, health assessments, care planning, emergency after-hours attendance - first patient).

AN.0.18 Provision for Review of Practitioner Behaviour

Professional Services Review (PSR) Scheme

The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when they rendered or initiated the services. It is also an offence under Section 82 for a person who is an officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Services Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Services Australia can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

Following a review, the Director must:

(a) decide to take no further action; or

(b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

(c) refer the matter to a PSR Committee.

A PSR Committee consists of the Chairperson and two other panel members who must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:

(a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

(b) hold hearings and require the person under review to attend and give evidence; and

(c) require the production of documents (including clinical notes).

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information on the Professional Services Review is available at www.psr.gov.au.

Penalties

Penalties of up to $10,000 or imprisonment for up to five years, or both may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee (MPRC) and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on an assignment of benefit form without necessary details having been entered on the form before the patient signs or who fails to cause a patient to be given a copy of the completed form.

Medicare Participation Review Committee (MPRC)

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences; or

(b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

AN.0.19 After-Hours Attendances (Items 585, 588, 591, 594, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5071, 5076, 5077, 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228, 5260, 5261, 5262, 5263, 5265 and 5267)

After-hours attendance items may be claimed as follows:

Items 585, 588, 591, 594, 599, 600 apply only to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Items 5000, 5020, 5040, 5060, 5071, 5200, 5203, 5207, 5208 and 5209 apply only to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1 pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5220, 5223, 5227, 5228, 5260, 5261, 5262, 5263, 5265 and 5267 apply to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Urgent After-Hours Attendances (Items 585 - 600)

Items 585, 588, 591, 594, 599 and 600 can be used for urgent after-hours services.

Urgent After-Hours Attendances (Items 585, 588, 591, and 594) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after-hours period.

Urgent After-Hours Attendances during Unsociable Hours (Items 599 and 600) allow for urgent attendances between 11pm and 7am in an after-hours period.

The attendance for all these items must be requested by the patient or a responsible person during the same unbroken urgent after-hours period in which the medical service is provided. The medical practitioner must first determine that the patient requires urgent medical assessment.

In considering the need for an urgent assessment of a patient's condition, the practitioner may rely on information conveyed by the patient or patient's carer, other health professionals or emergency services personnel. A record of the assessment must be completed and included in the patient's medical record.

The MBS urgent after-hours items may be used when, on the information available to the medical practitioner, the patient's condition requires urgent medical assessment during the after-hours period to prevent deterioration or potential deterioration in their health. Specifically, the patient's assessment:

· cannot be delayed until the next in-hours period; and

· the medical practitioner must attend the patient at the patient's location or reopen the practice rooms.

Appendix B of the Approved Medical Deputising Service (AMDS) Program Guidelines offers a useful protocol to determine whether prospective after-hours patients should be seen by a deputising medical practitioner or see their regular medical practitioner. The Guidelines are available on the Department of Health and Aged Care website at AMDS Program Guidelines.

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.

MBS Item 585 is available to medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by Services Australia; or

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Continuing Professional Development Program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

NOTE: MBS incentives continue to be available through the After-Hours Other Medical Practitioners (AHOMPs) Program to non-vocationally recognised medical practitioners who perform after-hours attendances. MBS item 585 will be available to AHOMPs Program participants if they perform an urgent after-hours attendance as part of their employment with a full-time general practice.

AHOMPs will not extend access to item 585 to non-vocationally recognised medical practitioners who work with an after-hours only practice or a medical deputising service (including an AMDS).

MBS Item 588 is available to non-vocationally recognised medical practitioners who are providing services (as a contractor, employee, member or otherwise) for a general practice or clinic or as part of medical deputising arrangements in Modified Monash Model Areas 2 to 7.

A locator map to identify a medical practice's Modified Monash Model Area location is on the Health Workforce Locator.

MBS item 591 is available to non-vocationally recognised medical practitioners who perform attendances for after-hours clinics or as part of deputising arrangements in Modified Monash Model Area 1.

If more than one patient is seen on the same occasion (that is, the second and any further services are consequential to the first service) using either MBS items 585, 588 or 591.

MBS item 594 must be used in respect of the second and subsequent services to patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms, will not be able to bill urgent after-hours items 585, 588, 591, 594, 599 and 600.

A *routine service* means a regular or habitual provision of services to patients. This does not include *ad hoc* services provided after-hours in consulting rooms by a medical practitioner (excluding consultant physicians and specialists) working in a general practice or a clinic while participating in an on-call roster.

There is no change to the types of providers who can render services under the *Urgent After-Hours Attendances during Unsociable Hours items* (MBS items 599 and 600). Attendances using these items must be booked during the same unbroken urgent after-hours period.

MBS item 599 continues to be available to medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by Services Australia; or

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Continuing Professional Development Program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard non-vocationally recognised medical practitioners through the AHOMPs Program; or

- non-vocationally recognised medical practitioners participating in the AHOMPs Program.

MBS item 600 continues to be available to non-vocationally recognised medical practitioners.

Non-Urgent After-Hours Attendances (5000 - 5077 and 5200 - 5267)

Non-Urgent After-Hours Attendances in Consulting Rooms (Items 5000, 5020, 5040, 5060, 5071, 5200, 5203, 5207, 5208 and 5209) are to be used for non-urgent consultations at consulting rooms initiated either on a public holiday, on a Sunday, or before 8am and after 1pm on a Saturday, or before 8am and after 8pm on any other day.

Non-Urgent After-Hours Attendances at a Place Other than Consulting Rooms (Other than a Hospital or Residential Aged Care Facility) (items 5003, 5023, 5043, 5063, 5076, 5220, 5223, 5227, 5228 and 5261) and *Non-Urgent After-Hours Attendances in a Residential Aged Care Facility* (Items 5010, 5028, 5049, 5067, 5077, 5260, 5262, 5263, 5265 and 5267) are to be used for non-urgent attendances on 1 or more patients on 1 occasion on a

public holiday, on a Sunday, or before 8am and after 12 noon on a Saturday, or before 8am and after 6pm on any other day.

Attendance Period	Applicable Time			Items
	Monday to Friday	Saturday*	Sunday and/or public holiday	
Urgent after-hours attendance	Between 7am - 8am and 6pm - 11pm	Between 7am - 8am and 12 noon - 11pm	Between 7am - 11pm	585, 588, 591, 594
Urgent after-hours in unsociable hours	Between 11pm - 7am	Between 11pm - 7am	Between 11pm - 7am	599, 600
Non-urgent After hours In consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	24 hours	5000, 5020, 5040, 5060, 5071 5200, 5203, 5207, 5208, 5209
Non-urgent after-hours at a place other than consulting rooms (other than a hospital or Residential Aged Care Facility)	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5003, 5023, 5043, 5063, 5076 5220, 5223, 5227, 5228, 5261
Non-urgent after-hours in a Residential Aged Care Facility	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5010, 5028, 5049, 5067, 5077 5260, 5262, 5263, 5265, 5267

*with the exception of public holidays which fall on a Saturday

AN.0.21 Minor Attendance by a Consultant Physician (Items 119, 120, 131)

A minor consultation is regarded as being a consultation in which the assessment of the patient does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment. Examples of consultations which could be regarded as being 'minor consultations' are listed below (this is by no means an exhaustive list) :-

- hospital visits where a physical examination does not result, or where only a limited examination is performed;

- hospital visits where a significant alteration to the therapy or overall management plan does not ensue;

- brief consultations or hospital visits not involving subsequent discussions regarding patient's progress with a specialist colleague or the referring practitioner.

AN.0.22 Telehealth Patient-end Support Services by Optometrists

Telehealth Patient-end Support Services by Optometrists

These notes provide information on the telehealth MBS attendance items for optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945 and 10946 in Group A10.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- this is necessary for the provision of the specialist service.

A video consultation will involve a single optometrist attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end. The above time-tiered items provide for patient-end support services in various settings, including consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

The ophthalmologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the ophthalmologist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The optometrist who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a medical practitioner, practice nurse, Aboriginal or Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The optometrist must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Record Keeping

Telehealth optometrists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Also, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face-to-face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Duration of attendance

The optometrist attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the ophthalmologist. The MBS fee payable for the supporting optometrist will be determined by the total time spent assisting the patient. This time does not need to be continuous.

AN.0.23 Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)

Patients with at least two morbidities which can include complex congenital, development and behavioural disorders are eligible for these services when referred by their referring practitioner.

Item 132 should include the development of options for discussion with the patient, and family members, if present, including the exploration of treatment modalities and the development of a comprehensive consultant physician treatment and management plan, with discussion of recommendations for services by other health providers as appropriate.

Item 133 is available in instances where a review of the consultant physician treatment and management plan provided under item 132 is required, up to a maximum of two claims for this item in a 12 month period. Should further reviews of the consultant physician treatment and management plan be required, the appropriate item for such service/s is 116.

Where a patient with a GP health assessment, GP management plan (GPMP) or Team Care Arrangements (TCA's) is referred to a consultant physician for further assessment, it is intended that the consultant physician treatment and management plan should augment the GPMP or TCA's for that patient.

Preparation of the consultant physician treatment and management plan should be in consultation with the patient. If appropriate, a written copy of the consultant physician treatment and management plan should be provided to the patient. A written copy of the consultant physician treatment and management plan should be provided to the referring medical practitioner, usually within two weeks of the consultant physician consultation. In more serious cases, more prompt provision of the plan and verbal communication with the referring medical practitioner may be appropriate. A guide to the content of such consultant physician treatment and management plans which are to be provided under this item is included within this Schedule.

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.)

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

- The following content outline is indicative of what would normally be sent back to the referring practitioner.

- The consultant physician treatment and management plan should address the specific questions and issues raised by the referring practitioner.

History

The consultant physician treatment and management plan should encompass a comprehensive patient history which addresses all aspects of the patient's health, including psychosocial history, past clinically relevant medical history, any relevant pathology results if performed and a review of medication and interactions. There should be a particular focus on the presenting symptoms and current difficulties, including precipitating and ongoing conditions. The results of relevant assessments by other health professionals, including GPs and/or specialists, including relevant care plans or health assessments performed by GPs under the Enhanced Primary Care and Chronic Disease Management should also be noted.

Examination

A comprehensive medical examination means a full multi-system or detailed single organ system assessment. The clinically relevant findings of the examination should be recorded in the management plan.

Diagnosis

This should be based on information obtained from the history and medical examination of the patient. The list of diagnoses and/or problems should form the basis of any actions to be taken as a result of the comprehensive assessment. In some cases, the diagnosis may differ from that stated by the referring practitioner, and an explanation of why the diagnosis differs should be included. The report should also provide a risk assessment, management options and decisions.

Management plan

Treatment options/Treatment plan

The consultant physician treatment and management plan should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options. Consideration should also be given to recommendations for allied health professional services, where appropriate.

Medication recommendations

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

Social measures

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

Other non medication measures

This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations and discussion of any relevant referrals to other health providers.

Indications for review

It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using the consultant physician treatment and management plan. If there are particular concerns about the indications or possible need for further review, these should be noted in the consultant physician treatment and management plan.

Longer term management

Provide a longer term consultant physician treatment and management plan, listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as anticipated response times, adverse effects and interactions with the consultant physician treatment and management plan options recommended under the consultant physician treatment and management plan.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the Department of Health and Aged Care's website.

AN.0.24 Attendance services for complex neurodevelopmental disorders (such as autism spectrum disorder)

Intention of this service under item 135 and telehealth equivalent item 92140

Items 135 or telehealth equivalent item 92140 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for neurodevelopmental disorders, which are assessed to be complex and mean that individuals require support across multiple domains.

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a paediatrician, for individuals diagnosed with a complex neurodevelopmental disorder (NDD). The development of the treatment and management plan, follows a comprehensive medical assessment, and provides the opportunity to refer to eligible Allied Health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Eligibility:

In the context of item 135 (or 92140), the diagnosis of a complex neurodevelopmental disorder requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains. **Complexity** is characterised by multi-domain cognitive and functional disabilities, delay or clinically significant impairment.

Neurodevelopmental domains include:

- Cognition
- Language
- Social-emotional development
- Motor skills
- Adaptive behaviour: conceptual skills, practical skills, social skills or social communication skills

Age eligibility:

Whilst it is not expected that a paediatrician would routinely assess adult individuals (item 289 provides for assessments undertaken by a psychiatrist for patients aged over 18 years to under 25 years), item 135 provides an age ceiling which is consistent across all MBS items related to complex neurodevelopmental disorders and related Allied Health services. Where a paediatrician has been referred a patient (under 18 years of age) and the diagnostic formulation is not completed until after their 18th birthday, the higher age limit will allow the completion of the assessment by the paediatrician (as clinically appropriate).

Referral pathways:

Early identification of, and intervention for, individuals with complex NDD is important in promoting positive longer term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where neurodevelopmental concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more specialised assessment, they are encouraged to refer to either a consultant paediatrician or psychiatrist for a comprehensive assessment.

Diagnostic Assessment:

The assessment and diagnosis of a complex NDD should be evaluated in the context of both a physical and developmental assessment. The paediatrician may require a number of separate attendances (through usual time-

tiered or subsequent attendance items 110, 116, 119, 122, 128, 131 or telehealth items 91824 to 91826) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected complex NDD, the consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the paediatrician determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an Allied Health practitioner, they are able to refer the patient to an eligible Allied Health provider from standard attendance items (110 to 131 or telehealth items 91824 to 91826 and 91834 to 91836).

Whilst Medicare rebates provide for a total of 8 Allied Health assessment services per patient per lifetime, an eligible Allied Health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible Allied Health professional) by the referring paediatrician, who must agree to the need for any additional Allied Health services prior to the delivery of the remaining 4 Allied Health assessment services.

Eligible Allied Health Assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech Pathologist (MBS item 82005, 93033, 93041)
- Occupational Therapist (82010, 93033, 93041)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to Allied Health practitioners

The paediatrician can refer to multiple eligible Allied Health practitioners concurrently, but a separate referral letter must be provided to each Allied Health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each Allied Health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 Allied Health Assessment services

Where an eligible Allied Health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041) and considers additional assessment services are required, they must ensure the referring paediatrician undertakes a review. If the type of review is not specified by the referring paediatrician an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring paediatrician.

Inter-disciplinary Allied Health referral

Eligible Allied Health practitioners are also able to make inter-disciplinary referrals to other eligible Allied Health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring paediatrician. Whilst they do not require the need for an attendance with the patient (face-to-face or telehealth) by the referring paediatrician, they do require an agreement from the referring paediatrician. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through Allied Health referral

In addition to referring to Allied Health practitioners for assistance with formulating a diagnosis, once a paediatrician makes a complex neurodevelopmental disorder diagnosis, the paediatrician may require the

contribution of an eligible Allied Health practitioner to assist with the development of the Treatment and Management plan (before billing item 135 or 92140).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring paediatrician should be mindful of this when referring to eligible Allied Health practitioners.

Development of the Treatment and Management Plan

Once the paediatrician has made a diagnosis of a complex neurodevelopmental disorder, to complete the item requirements of item 135 or 92140 they must develop a treatment and management plan which includes:

Written documentation of the patient's confirmed diagnosis of a complex neurodevelopmental disorder, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)

- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identify major treatment goals and important milestones and objectives
    - Recommendation and referral for treatment services provided by eligible Allied Health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to the referring medical practitioner and relevant Allied Health practitioner/s.

Referral for Allied Health Treatment services

Once a treatment and management plan is in place (under item 135 or 92140) the paediatrician can refer the individual to eligible Allied Health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible Allied Health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech Pathologist (MBS items 82020, 93036, 93044)
- Occupational Therapist (MBS items 82025, 93036, 93044)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 Allied Health Treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent telehealth items. Whilst the paediatrician can refer to multiple eligible Allied Health practitioners concurrently, a separate referral letter must be provided to each Allied Health practitioner.

The referral should specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring paediatrician to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS Allied Health Treatment services unless the pre-requisite items (135 or 92140) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring paediatrician, up to maximum of 10 services), the eligible Allied Health practitioner must provide a written report to the referring paediatrician, which should include information on the treatment provided, recommendations on future management of the individual's disorder and any advice to caregivers (such as parents, carers, school teachers). This written report will inform the referring paediatrician's decision to refer for further treatment services. Where subsequent courses of treatment are required after the initial 10 services (up to a maximum of 20 services per patient per lifetime) a new referral is required.

Inconclusive assessment:

Where a patient does not meet the diagnostic threshold of a complex neurodevelopmental disorder and where ongoing medical management is required, patients can be managed through subsequent attendance items (such as 116 or 91825) or where at least two separate diagnoses are made through item 132 or 92422.

Examples include where:

- Neurodevelopment assessment is incomplete or inconclusive
- Neurodevelopmental impairment is present in fewer than two domains
- Neurodevelopmental impairment is present in two or more domains, but individuals do not require sufficient support to meet criteria
- Comprehensive, age-appropriate neurodevelopmental assessment is impossible or unavailable (e.g. in infants or young children- particularly those under 6 years of age)

These individuals may be considered "at risk of a complex neurodevelopmental" and require follow-up and reassessment in the future.

AN.0.25 Attendance services for eligible disabilities

Intention and eligibility of this service under item 137 and telehealth equivalent item 92141

Items 137 or telehealth equivalent item 92141 are intended for diagnosis and treatment for patients under 25 years of age with an eligible disability by a specialist or consultant physician.

Definition of Eligible Disabilities is found at AR.29.1.

Referral pathways:

Early identification of, and intervention for, individuals with eligible disabilities is important in promoting positive longer-term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where indications of eligible disability concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more specialised assessment, they are encouraged to refer to a specialist or consultant physician for a comprehensive assessment.

Diagnostic Assessment:

The assessment and diagnosis of an eligible disability should be evaluated in the context of both a physical and developmental assessment. The specialist or consultant physician may require a number of separate attendances (through usual time-tiered or subsequent attendance items 104, 105, 107, 108, 110, 116, 119, 122, 128, 131, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 324, 326, 328, 330, 332, 334, 336, 338, 341, 342, 343, 344, 345, 346, 347 or 349 or telehealth items 91822 to 91831, 91833, 91836 to 91839, 91868 to 91878 to 91882 to 91884, 92437 or 92455 to 92460) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the specialist or consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the specialist or consultant physician determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an Allied Health practitioner, they are able to refer the patient to an eligible Allied Health practitioner from standard attendance items 104, 105, 107, 108, 110, 116, 119, 122, 128, 131, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 324, 326, 328, 330, 332, 334, 336, 338, 341, 342, 343, 344, 345, 346, 347 or 349 or telehealth items 91822 to 91831, 91833, 91836 to 91839, 91868 to 91878 to 91882 to 91884, 92437 or 92455 to 92460.

Whilst MBS items provide for a total of 8 Allied Health assessment services per patient per lifetime, an eligible Allied Health practitioner can only provide up to 4 services before the need for a review (the type of review can be specified in the referral to the eligible Allied Health practitioner) by the referring specialist or consultant physician, who must agree to the need for any additional Allied Health services prior to the delivery of the remaining 4 Allied Health assessment services.

Eligible Allied Health assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech Pathologist (MBS item 82005, 93033, 93041)
- Occupational Therapist (MBS item 82010, 93033, 93041)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to Allied Health practitioners

The specialist or consultant physician can refer to multiple eligible Allied Health practitioners concurrently, but a separate referral letter must be provided to each Allied Health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each Allied Health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 Allied Health assessment services

Where an eligible Allied Health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041) and considers additional assessment services are required, they must ensure the referring specialist or consultant physician undertakes a review. If the type of review is not specified by the referring specialist or consultant physician an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary Allied Health referral

Eligible Allied Health practitioners are also able to make inter-disciplinary referrals to other eligible Allied Health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring specialist or consultant physician. Whilst they do not require the need for an attendance with the patient (face-to-face or telehealth) by the referring specialist or consultant physician, they do require an agreement from the referring specialist or consultant physician. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the treatment and management plan through Allied Health referral

In addition to referring to Allied Health practitioners for assistance with formulating a diagnosis, once the specialist or consultant physician makes a diagnosis, the specialist or consultant physician may require the contribution of an eligible Allied Health practitioner to assist with the development of the treatment and management plan (before billing item 137 or 92141).

MBS items 82000, 82005, 82010, 82030, 93032[BJ1] , 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring specialist or consultant physician should be mindful of this when referring to eligible Allied Health practitioners.

Development of the treatment and management plan

Once the specialist or consultant physician has made a diagnosis of an eligible disability, to complete the item requirements of item 137 or 92141 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of an eligible disability, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)
- A risk assessment which means assessment of:

  o the risk to the patient of a contributing co-morbidity and

  o environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.

- Treatment options which:

  o Recommendations using a biopsychosocial model

  o Identify major treatment goals and important milestones and objectives

  o Recommendation and referral for treatment services provided by eligible Allied Health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)

  o Indications for review or episodes requiring escalation of treatment strategies

- Documenting the treatment and management plan and providing a copy to the referring medical practitioner and relevant Allied Health practitioner/s.

Referral for Allied Health treatment services

Once a treatment and management plan is in place (after item 137 or 92141 has been claimed) the specialist or consultant physician can refer the individual to eligible Allied Health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible Allied Health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech Pathologist (MBS items 82020, 93036, 93044)
- Occupational Therapist (MBS items 82025, 93036, 93044)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 Allied Health treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent telehealth items. Whilst the specialist or consultant physician can refer to multiple eligible Allied Health practitioners concurrently, a separate referral letter must be provided to each Allied Health practitioner.

The referral must specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS Allied Health treatment services unless the pre-requisite items (137 or 92141) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring specialist or consultant physician, up to maximum of 10 services), the eligible Allied Health practitioner must provide a written report to the referring specialist or consultant physician, which must include information on the treatment provided, recommendations for future management of the individual's disorder and any advice to caregivers (such as parents, carers, schoolteachers). This written report will inform the referring specialist or consultant physician's decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

AN.0.26 Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)

Items 141 -147 apply only to services provided by a consultant physician or specialist in the specialty of Geriatric Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine.

Referral for Items 141-147 should be through the general practitioner for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. In the event that a specialist of another discipline wishes to refer a patient for this item, the referral should take place through the GP.

A comprehensive assessment of an older person should as a minimum cover:

· current active medical problems

· past medical history;

· medication review;

· immunisation status;

· advance care planning arrangements;

· current and previous physical function including personal, domestic and community activities of daily living;

· psychological function including cognition and mood; and

· social function including living arrangements, financial arrangements, community services, social support and carer issues.

Note: Guidance on all aspects of conducting a comprehensive assessment on an older person is available on the Australian and New Zealand Society for Geriatric Medicine website at www.anzsgm.org.

Some of the information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the geriatrician. The remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician.

A prioritised list of diagnoses/problems should be developed based on information provided by the history and examination, and any additional information provided by other means, including an interview of a person other than the patient.

The management plan should be explained and if necessary provided in written form to the patient or where appropriate, their family or carer(s).

A written report of the assessment including the management plan should be provided to the general practitioner within a maximum of 2 weeks of the assessment. More prompt verbal communication may be appropriate.

The Patient Assessment and Management plans must be kept for 2 years after the date of service.

Items 143 and 147 are available in instances where the GP initiates a review of the management plan provided under items 141 and 145, usually where the current plan is not achieving the anticipated outcome. It is expected that when a management plan is reviewed, any modification necessary will be made.

Items 143 and 147 can be claimed once in a 12 month period. However, if there has been a significant change in the patient's clinical condition or care circumstances necessitating another review, an additional item 143 or 147 can be claimed. In these circumstances, the patient's invoice or Medicare voucher should be annotated to briefly indicate the reason why the additional review was required (e.g. annotated as clinically indicated, exceptional circumstances, significant change etc).

AN.0.27 Prolonged Attendance in Treatment of a Critical Condition (Items 160 164)

The conditions to be met before services covered by items 160-164 attract benefits are:-

(i) the patient must be in imminent danger of death;

(ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and

(iii) if personal attendance on a single patient is provided by 1 or more general practitioners, specialists or consultant physicians concurrently, each general practitioner, specialist or consultant physician may claim an attendance fee.

AN.0.28 Family Group Therapy (Items 170, 171, 172)

These items refer to family group therapy supervised by general practitioner, specialist or consultant physician (other than consultant psychiatrists). To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

AN.0.29 Acupuncture (Item 193, 195, 197 and 199)

Items 193, 195, 197 and 199 cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, eg by application of ultrasound, laser beams, pressure or moxibustion, etc.

For more information on the content-based item structure used in this Group, see para AN.0.9 of explanatory notes to this Category.

AN.0.30 Consultant Psychiatrist - Referred Patient Assessment and Management Plan - Items 291 or 92435 and 293 or 92436

Intention of Item 291 and 92435:

It is expected that item 291 or 92435 will be a single attendance. The intention of this item is to provide access to psychiatry expertise and the provision of a detailed written report to the referrer, so that the medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or participating nurse

practitioner can provide the ongoing management of the patient. The detailed report is a fundamental component of this item and must address not only a comprehensive diagnostic assessment but also the recommended management of the patient in both the immediate and longer term.

Where a patient's clinical needs are complex and the psychiatrist assesses it is not appropriate for the referrer to provide the ongoing management of the patient, the psychiatrist should use item 296, 297 or 299 (for a new patient) or 300, 302, 304, 306 or 308 (for subsequent attendance) or telehealth equivalent items 92437, 91827 to 91831, 91837 to 91839 (refer to Note AN.0.75).

The referrer can seek a revision of this management plan once in a 12 month period, through item 293 or 92436.

Referral:

Referral for items 291 or 92435 and 293 or 92436 are required from a medical practitioner in general practice or participating nurse practitioner for the assessment and development of a management plan of a patient with mental health condition.

Note: If a specialist of a discipline outside of psychiatry, wishes to refer a patient for this item the referral should take place through the medical practitioner in general practice or participating nurse practitioner.

Claiming other psychiatry items in association with 291 or 92435:

Whilst it is not expected that additional attendance items would be routinely used prior to item 291 or 92435, there may be circumstances where a patient has been referred (by a medical practitioner in general practice or participating nurse practitioner) for an assessment or management plan, but it is not possible for the psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan.

In those circumstances, where the psychiatrist undertakes a consultation prior to the 291 or 92435 consultation, time based consultation items can be claimed, according to the item requirements. In these cases, where clinically appropriate, items 296, 297 or 299 (for a new patient) or 300, 302, 304, 306 or 308 (for subsequent attendance) or telehealth equivalent items (92437, 91827 to 91831, 91837 to 91839) may be used. Non-patient interview items 341, 343, 345, 347 or 349 or telehealth equivalent items 91874 to 91878, 91882 to 91884 may be used, where clinically appropriate, to assist with diagnosis assessment and preparation of treatment plans.

Claiming other psychiatry items following item 291 or 92435:

Whilst it is not expected that psychiatry time-based attendance items, such as items 300 to 308, would be used following the billing of item 291 or 92435, there may be clinical circumstances where limited follow up is required to provide short term assistance to enable the medical practitioner in general practice or participating nurse practitioner to provide the ongoing management of the patient. For example, one or two consultations monitoring the titration of a Schedule 8 medication prior to transfer of care back to a medical practitioner in general practice. As the intention of this item is to provide detailed recommendations to the referrer to manage the patient's ongoing care, only short-term non-ongoing management which enables this intent would be considered appropriate.

Item 293 or 92436 provides opportunity for a comprehensive review of the management plan initiated by the referrer and can be claimed once in a 12 month period following use of item 291 or 92435.

Requirements of item 291 or 92435 - Use of outcome tools:

In order to contribute to the diagnostic assessment and monitor response to therapy, where clinically appropriate, an assessment and/or outcome tool should be utilised during the assessment and review stage of treatment. The choice of the evidence-based tool/s to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)

- Health of the Nation Outcome Scales (HoNOS)
- DASS 21 (Depression, Anxiety and Stress)
- BDI (Depression)
- BAI (Anxiety)
- BDRS (Bipolar Disorder)
- YBOCS (OCD)
- GRS (Older adults)
- EPDS (Postnatal Depression)

Requirements of item 291 or 92435 - Management Plan Report:

A written copy of the detailed management plan in consultation with the patient, must be provided to the referring GP or participating nurse practitioner within a maximum of two weeks of the assessment.

It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the referring GP or participating nurse practitioner may be appropriate.

The detailed Management Plan **should** contain:

- The findings of the comprehensive diagnostic assessment and the formulation that contributed to this assessment (including the finding of the outcome tools where clinically appropriate)
- Relevant history and Mental Status Examination
- Identification of any risks to the patient or others
- Detailed management plan which includes, as clinically appropriate, not limited to one or more of the following recommendations:

    - Biopsychosocial management

    - Non-medication recommendations including (where relevant): psychoeducation; recommendations for psychological treatment (and who should provide this); social prescribing

    - Indications for review or episode and escalation of treatment strategies

    - Longer term management goals

Review of Management Plan - Item 293 or 92436:

Item 293 or 92436 is available in instances where the referring medical practitioner in general practice or participating nurse practitioner initiates a review of the plan provided under item 291 or 92435, usually where the current plan is not achieving the anticipated outcome or there has been a change in the clinical circumstances. It is expected that when a plan is reviewed, any modifications necessary will be made. Item 293 or 92436 can only be claimed once in a 12 month period, following the provision of a service under 291 or 92435.

AN.0.31 Psychiatric Attendances (Items 319 and 91873)

Item 319 or 91873 provides for an attendance, by a psychiatrist, to provide intensive psychotherapy where the patient's clinical condition requires intensive treatment. Clinical appropriateness and indications for intensive psychotherapy are determined following a comprehensive assessment and formulation of a diagnosis and should be documented in the patient's notes. It is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. Such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long-term psychotherapy; pharmacological therapy; and cognitive behaviour therapy.

Once a patient is identified as meeting the criteria of item 319 or 91873, eligibility continues under that item for the duration of that course of treatment (provided that attendances under items 296, 297, 299, 300, 302, 304, 306, 308, 319, 91827 to 91831, 91837 to 91839, 91873 and 92437 do not exceed 160 in a calendar year). If the patient requires

more than 160 services in a calendar year for intensive psychotherapy, then such attendances would be covered by items 310, 312, 314, 316, 318, 91868 to 91872 or 91879 to 91881.

AN.0.32 Interview of Person other than a Patient by Consultant Psychiatrist (Items 341, 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884)

Intention of these items:

Items 341, 343, 345, 347 and 349 and telehealth equivalent items 91874 to 91878 and 91882 to 91884 are for the purpose of interviews with patient relatives or close associates to investigate the particular problem with which the patient presented or the interaction between the patient and the person interviewed. The items also provide for interviews concerned with the continuing management of the patient, focusing on clinically relevant problems rising in the management of the patient.

These items do not cover counselling of family or friends of the patient.

Referral requirements:

The patient who is the subject of the interview needs a referral to attend the psychiatrist in the first place, however the non-patient contacts who are interviewed do not require their own referral.

Claiming of Medicare benefits:

The payment of Medicare benefits under these items is limited to a total of 15 services in a calendar year.

For Medicare benefit purposes, claims relating to services covered by items 341, 343, 345, 347, 349 and telehealth equivalent items 91874 to 91878 and 91882 to 91884 should be raised against the patient rather than against the person interviewed.

Same day attendance items:

Medicare benefits are payable on the same day for an interview under any of items 341, 343, 345, 347 and 349 or telehealth equivalent items 91874 to 91878 and 91882 to 91884 and for a consultation with a patient (under item 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326 or 328) provided that separate attendances are involved. This item can only be claimed if the interviewee attends without the patient.

AN.0.33 Consultant Occupational Physician Attendances (Items 385 to 388)

Attendances by consultant occupational physicians will attract Medicare benefits only where the attendance relates to one or more of the following:

(i) evaluation and assessment of a patient's rehabilitation requirements where the patient presents with an accepted medical condition(s) which may be affected by the consultant occupational physician's working environment or employability; or

(ii) management of accepted medical condition(s) which may affect a patient's capacity for continued employment or return to employment following a non-compensable accident, injury or ill-health; or

(iii) evaluation and opinion and/or management of a patient's medical condition(s) where causation may be related to acute or chronic exposures from scientifically accepted environmental hazards or toxins.

AN.0.34 Contact Lenses (Items 10801-10809)

Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in items 10801 to 10809.

Benefits are not payable for item 10809 in circumstances where patients want contact lenses only for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses. Subsequent follow-up attendances attract benefits on a consultation basis.

AN.0.35 Refitting of Contact Lenses (Item 10816)

This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

AN.0.36 Time-Tiered Health Assessments (Items 701, 703, 705, 707, 224, 225, 226, 227)

Publication date: 1 July 2024

SUMMARY

This note sets out common principles that apply when using MBS time-tiered health assessment items for general practitioners (GPs see GN.4.13) and prescribed medical practitioners (PMPs see AN.7.1).

Time-tiered health assessment items are only available to specific patient cohorts. Details of the requirements for a health assessment for each patient cohort are at:

- Type 2 diabetes risk evaluation (40-49 years) – see AN.0.37.
- Health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease – see AN.0.38.
- Health Assessment provided for people aged 75 years and older – see AN.0.39.
- Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities – see AN.0.40.
- Health Assessment provided for people with an intellectual disability – see AN.0.41.
- Health Assessment provided for refugees and other humanitarian entrants – see AN.0.42.
- One-off health assessment for veterans – see AN.0.69.

USE OF THE ITEMS

Health assessment items are used to assess eligible patients' health and physical, psychological and social function. This includes the medical practitioner's consideration of whether preventive health care and education should be offered to the patient to improve their health or function.

The items apply only to a service provided in the course of a personal attendance by a single GP or PMP on a single patient.

While the requirements for health assessments vary according to patient cohort, in general they all require the GP or PMPs to undertake a range of activities, including:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required
- making an overall assessment of the patient
- recommending appropriate interventions, and
- providing advice and information to the patient.

Additional item requirements apply to all health assessments conducted, tailored to meet the needs of each patient group being targeted under the items (see 'Eligible Patients'). Information on additional item requirements is available in Notes: AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69.

How do I choose which health assessment item to use?

The correct health assessment item will depend on:

- practitioner type – GP or PMP, and
- length of time spent with the patient (i.e. the personal attendance time).

Health Assessment service	GP	PMP
Brief health assessment lasting no more than 30 minutes	701	224
Standard health assessment lasting at least 30 minutes and less than 45 minutes	703	225
Long health assessment lasting at least 45 minutes and less than 60 minutes	705	226
Prolonged health assessment lasting more than 60 minutes	707	227

Are there specific requirements for any of the health assessment items?

Yes, additional item requirements apply to all health assessments conducted, tailored to meet the needs of each patient group being targeted under the items (see 'Eligible Patients'). Information on additional item requirements is available in Notes: AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69.

Is a health assessment a health screening service?

No. Clause 2.15.14 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) specifies that a time-tiered health assessment must not include a screening service.

The *Health Insurance Act 1973* defines a health screening service as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. A health screening service does not include a medical examination or a test on a symptomless patient by the that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health.

Further information is available in Note GN.13.33.

Can another person assist the medical practitioner to undertake the health assessment?

Yes. Clause 2.15.14 of the Regulations states that practice nurses, Aboriginal health workers and Aboriginal Torres Strait Islander health practitioners may assist in accordance with accepted medical practice under the supervision of the medical practitioner.

Assistance provided must be in accordance with accepted medical practice and under the supervision of the GP or prescribed medical practitioner. This may include activities associated with:

- information collection, and
- providing patients with information about recommended interventions, at the direction of the medical practitioner.

The GP or prescribed medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

MBS items for Time-Tiered Health Assessments are for a complete service. For and on behalf of item 10997 may not be claimed in conjunction with these items.

Additional advice on the use of other health professionals' time when undertaking health assessments can be found in the AskMBS Advisory – General Practice 1 (health.gov.au).

A *Practice nurse* means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or eligible health service.

An *Aboriginal and Torres Strait Islander health practitioner* means a person who:

- is registered under a law of a State or Territory as an Aboriginal and Torres Strait Islander health practitioner, and
- is employed by, or whose services are otherwise retained by, a GP or prescribed medical practitioner in a general practice, or an eligible health service.

An *Aboriginal health worker* means a person who:

- holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualification, and
- is engaged by a GP or prescribed medical practitioner in a general practice or an eligible health service.

Can I include additional time required for communications (e.g. with an interpreter) in the time taken for the health assessment?

Yes, a wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service.

In such situations, medical practitioners should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

My patient is eligible for more than one category of health assessment. Which health assessment should I do?

Patients can receive each health assessment they are eligible for. For example, a 42 year old patient with an intellectual disability who is also found to be at high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool can receive:

- a health assessment for a person with an intellectual disability annually, and
- a type 2 diabetes risk evaluation every 3 years until they are 49 (inclusive).

Where the patient is eligible for more than one health assessment there is no minimum interval of time between the provision of the different health assessments. Where patients are eligible for more than one health assessment practitioner should ensure they identify which target group the health assessment relates to when submitting claims to Services Australia. Additional information on claiming limits is available on the Services Australia - Health assessments and your record keeping responsibilities webpage.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits and meets the criteria for one or more of the following target groups may receive a health assessment service, at the stated frequencies:

Target Group	Frequency of Service	Associated Note
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient	AN.0.37
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient	AN.0.38
A health assessment for people aged 75 years and older	Provided annually to an eligible patient	AN.0.39
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient	AN.0.40
A health assessment for people with an intellectual disability	Provided annually to an eligible patient	AN.0.41
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient	AN.0.42
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient	AN.0.69

Residential aged care facility-specific items are only available to Medicare-eligible patients that are residents of a residential aged care facility and who are currently not in-patients of a hospital.

All other health assessment items are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

ELIGIBLE PRACTITIONERS

Health assessment items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13).
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

Note: Clause 2.15.14 of the Regulations specifies patients must access health assessment services through their usual GP or prescribed medical practitioner, if reasonably practicable.

The patient's usual GP or prescribed medical practitioner means the practitioner:

- who has provided the majority of services to the patient in the past 12 months, or
- who is likely to provide the majority of services to the patient in the following 12 months, or
- is located at a medical practice that:
    - has provided the majority of services to the patient in the past 12 months, or
    - is likely to provide the majority of services to the patient in the next 12 months.

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.37 Time-tiered Health Assessment - Type 2 Diabetes Risk Evaluation

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake a Type 2 Diabetes Risk Evaluation for Medicare eligible patients aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Type 2 Diabetes Risk Evaluation are set out in clause 2.15.4 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a Type 2 Diabetes Risk Evaluation must include:

- a review of the risk factors underlying a patient's high-risk score as identified by the Australian Type 2 Diabetes Risk Assessment Tool, and
- initiating interventions, if appropriate, to address risk factors or to exclude diabetes.

The Regulations also state that the evaluation must include:

- assessing the patient's high-risk score as determined by the Australian Type 2 Diabetes Risk Assessment Tool
- updating the patient's history and performing physical examinations and clinical investigations
- making an overall assessment of the patient's risk factors and the results of examinations and investigations
- initiating interventions, if appropriate, including referrals and follow-up services relating to the management of any risk factors identified, and
- giving the patient advice and information, including strategies to achieve lifestyle and behaviour changes if appropriate.

For the purposes of a Type 2 Diabetes Risk Evaluation, risk factors include:

- lifestyle risk factors (e.g. smoking, physical inactivity or poor nutrition)
- biomedical risk factors (e.g. high blood pressure, impaired glucose metabolism or excess weight), and
- a family history of a chronic disease.

ELIGIBLE PATIENTS

Patients eligible for a Type 2 Diabetes Risk Evaluation are:

- aged between 40-49 years (inclusive), and
- have a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The Australian Type 2 Diabetes Risk Assessment Tool must have been completed by the patient no more than 3 months prior to the Type 2 Diabetes Risk Evaluation.

A Type 2 Diabetes Risk Evaluation cannot be claimed more than once every 3 years by an eligible patient.

ELIGIBLE PRACTITIONERS

Type 2 Diabetes Risk Evaluations can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with a Type 2 Diabetes Risk Evaluation, unless clinically necessary.

To co-claim a Type 2 Diabetes Risk Evaluation item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and where a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.38 Time-Tiered Health Assessment - People aged 45-49 years who are at risk of developing chronic disease

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

Note: The requirements below must be met in addition to common principles for time tiered health assessment items, contained in AN.0.36.

USE OF ITEMS

The specific requirements of the Type 2 Diabetes Risk Evaluation are set out in clause 2.15.5 of the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

The Regulations specify GPs (see GN.4.13) and prescribed medical practitioners (PMP, see AN.7.1) can provide this health assessment to patients, where in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease has been identified.

Specific risk factors the medical practitioner can consider when providing this health assessment include, but are not limited to:

- lifestyle risk factors (such as smoking, physical inactivity, poor nutrition or alcohol misuse)
- biomedical risk factors (such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight)
- a family history of a chronic disease.

The regulation states the health assessment must include:

- information collection, including taking a patient's history and performing examinations and investigations, as required
- making an overall assessment of the patient
  initiating interventions or referrals, as appropriate, and
  giving health advice and information to the patient.

The Regulations state that a chronic disease is one that "has been, or is likely to be, present for at least 6 months, including, but not limited to: asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition." It is important to note that this definition of a chronic disease is specific to this health assessment cohort. It does not apply more broadly across the MBS.

ELIGIBLE PATIENTS

Eligible patients for a health assessment for people who are at risk of developing a chronic disease are:

- aged between 45-49 years (inclusive), and
- are at risk of developing a chronic disease, in the clinical judgement of the attending medical practitioner based on the identification of a specific risk factor.

A health assessment for a patient at risk of developing a chronic disease cannot be claimed more than once per eligible patient.

ELIGIBLE PRACTITIONERS

A health assessment for patients at risk of developing a chronic disease can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment for patients at risk of developing a chronic disease, unless clinically necessary.

To co-claim the health assessment item for patients at risk of developing a chronic disease and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.39 Time-Tiered Health Assessment - Older Person's Health Assessment provided for people aged 75 years and older

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake an Older Person's health assessment for Medicare eligible patients aged 75 years and older every 12 months.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Older Person's health Assessment are set out in clause 2.15.6 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The regulations state that an Older Person's health assessment is the assessment of:

- a patient's health and physical, psychological and social function, and
- whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological and social function.

The Regulations also state that the health assessment must include:

- personal attendance by a general practitioner or prescribed medical practitioner
- measurement of the patient's blood pressure, pulse rate and rhythm
- an assessment of the patient's medication
- an assessment of the patient's continence
- an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus
- an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months
- an assessment of the patient's psychological function, including the patient's cognition and mood, and
- an assessment of the patient's social function, including:
    - the availability and adequacy of paid and unpaid help, and
    - whether the patient is responsible for caring for another person.

Note: The Regulations do not preclude a medical practitioner's consideration of the patient's broader immunisation status, such as for immunisations listed under the National Immunisation Program schedule or for COVID-19.

ELIGIBLE PATIENTS

Patients eligible for an Older Person's health assessment are:

- aged 75 years and older and not an in-patient of a hospital or a care recipient in a residential aged care facility.

For comprehensive medical assessments for residents of residential aged care facilities see AN.0.40.

An Older Person's health assessment cannot be claimed more than once every 12 months by an eligible patient.

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with an Older Person's health assessment service, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations state that an Older Person's health assessment must include:

- keeping a record of the health assessment
- offering the patient a written report on the health assessment, with recommendations about matters covered by the health assessment, and
- offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.40 Time-Tiered Health Assessment - Comprehensive Medical Assessment for care recipient in a residential aged care facility

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake a Comprehensive Medical Assessment for a care recipient of a residential aged care facility (RACF).

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Comprehensive Medical Assessment for care recipients in a RACF are set out in clause 2.15.7 of the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

The regulations require that a Comprehensive Medical Assessment for care a recipient in a RACF must include an assessment of the resident's health, physical and psychological function.

It must also include:

- a personal attendance by a general practitioner or prescribed medical practitioner
- taking a detailed patient history of the resident
- conducting a comprehensive medical examination of the resident
- developing a list of diagnoses and medical problems based on the medical history and examination, and

- making a written summary of the Comprehensive Medical Assessment.

ELIGIBLE PATIENTS

Patients eligible for a Comprehensive Medical Assessment are care recipients in a residential aged care facility. The Regulations define a care recipient as a person to whom residential care (as defined in section 41-3 of the Aged Care Act 1997) is provided.

A Comprehensive Medical Assessment may be provided on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided to the patient in another residential aged care facility in the last 12 months.

A Comprehensive Medical Assessment may be claimed by eligible patients:

- on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided in another residential aged care facility in the last 12 months, and
- at 12 month intervals after that assessment.

ELIGIBLE PRACTITIONERS

A Comprehensive Medical Assessment can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose, but must be claimed separately.

To co-claim a Comprehensive Medical Assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations state that a Comprehensive Medical Assessment must include:

- making a written summary of the Comprehensive Medical Assessment
- giving a copy of the summary to the residential aged care facility, and
- offering the resident a copy of the summary.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.41 Time-Tiered Health Assessment - Heath assessment for a person with an intellectual disability

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment for a person with an intellectual disability.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of a health assessment for a person with an intellectual disability are set out in clause 2.15.8 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations specify that a Health assessment for a person with an intellectual disability is an assessment of:

- the patient's physical, psychological and social function, and
- whether any medical intervention and preventive health care is required.

They also state that the health assessment must include the following matters, to the extent that they are relevant to the patient:

- checking dental health (including dentition)
- conducting an aural examination (including arranging a formal audiometry if an audiometry has not been conducted within the last 5 years)
- assessing ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within the last 5 years)
- assessing nutritional status (including weight and height measurements) and a review of growth and development
- assessing bowel and bladder function (particularly for incontinence or chronic constipation)
- assessing medications including:
    - non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications
    - advice to carers on the common side effects and interactions, and
    - consideration of the need for a formal medication review
- checking immunisation status (including influenza, tetanus, hepatitis A and B, measles, mumps, rubella and pneumococcal vaccinations)
- checking exercise opportunities (with the aim of moderate exercise for at least 30 minutes each day)
- checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required
- considering the need for breast examination, mammography, papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population
- checking for dysphagia and gastroesophageal disease (especially for patients with cerebral palsy) and arranging for investigation or treatment as required
- assessing risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication and fracture history) and arranging for investigation or treatment as required
- for a patient diagnosed with epilepsy—reviewing seizure control (including anticonvulsant drugs) and considering referral to a neurologist at appropriate intervals
- screening for thyroid disease at least every 2 years (or yearly for patients with Down syndrome)
- for a patient without a definitive aetiological diagnosis—considering referral to a genetic clinic every 5 years
- assessing or reviewing treatment for comorbid mental health issues
- considering timing of puberty and management of sexual development, sexual activity and reproductive health, and
- considering whether there are any signs of physical, psychological or sexual abuse.

Note: The Regulations do not preclude a medical practitioner's consideration of the patient's broader immunisation status, such as for immunisations listed under the National Immunisation Program schedule or for COVID-19.

Practitioners may also wish to utilise publicly available guidelines such as the Royal Australian College of General Practitioner's *Guidelines for preventative activities in general practice* as a guideline to conduct patient assessments to current clinical standards.

Eligible health practitioners may wish to consider the use of relevant assessment tools in the delivery of this service, such as the Adult Comprehensive Health Assessment Program (CHAP). However, it remains the responsibility of the treating practitioner to ensure all requirements of the items are met.

ELIGIBLE PATIENTS

Patients are eligible for this assessment if they are a person living with an intellectual disability.

A health assessment for a person with an intellectual disability cannot be claimed more than once every 12 months by an eligible patient.

ELIGIBLE PRACTITIONERS

Health assessment for a person with an intellectual disability can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a health assessment for a person with an intellectual disability item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

A health assessment for a person with an intellectual disability must include:

- keeping a record of the health assessment;
- offering the patient a written report on the health assessment;
- offering the patient's carer (if any, and if the general practitioner or the prescribed medical practitioner considers it appropriate, and the patient agrees) a copy of the report or extracts of the report; and
- offering relevant disability professionals (if the general practitioner or the prescribed medical practitioner considers it appropriate and the patient or, if appropriate, the patient's carer, agrees) a copy of the report or extracts of the report.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.42 Time-Tiered Health Assessment - Health Assessment provided for a refugee and other humanitarian entrant

Publication date: 1 July 2024

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment provided for a refugee or other humanitarian entrant.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the health assessment for a refugee or other humanitarian entrant are set out in clause 2.15.9 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a health assessment provided for a refugee or other humanitarian entrant is an assessment of:

- the patient's health and physical, psychological and social function, and
- whether preventive health care and education should be offered to the patient to improve their health and physical, psychological or social function.

The Regulations also state that the health assessment must include:

- a personal attendance by a GP or prescribed medical practitioner
- taking the patient's history
- examining the patient
- performing or arranging any required investigations
- assessing the patient, using the information gained from the above points
- developing a management plan addressing the patient's health care needs, health problems and relevant conditions, and
- making or arranging any necessary interventions and referrals.

A wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service.

In such situations, medical practitioners and other providers should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

ELIGIBLE PATIENTS

Patients are eligible for this assessment if they are:

- a refugee or humanitarian entrant, with eligibility for Medicare, and
- either:
    - hold a relevant visa that the person has held for less than 12 months at the time of the assessment, or

- first entered Australia less than 12 months before the assessment is performed.

A relevant visa means any of the following visas granted under the Migration Act 1958:

- Subclass 070 Bridging (Removal Pending) visa
- Subclass 200 (Refugee) visa
- Subclass 201 (In-country Special Humanitarian) visa
- Subclass 202 (Global Special Humanitarian) visa
- Subclass 203 (Emergency Rescue) visa
- Subclass 204 (Woman at Risk) visa
- Subclass 786 (Temporary (Humanitarian Concern)) visa
- Subclass 790 (Safe Haven Enterprise) visa
- Subclass 866 (Protection) visa

A health assessment provided for a refugee or other humanitarian entrant may only be claimed once by an eligible patient.

ELIGIBLE PRACTITIONERS

A health assessment provided for a refugee or other humanitarian entrant can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a health assessment provided for a refugee or other humanitarian entrant item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

A health assessment provided for a refugee or other humanitarian entrant must include:

- keeping a record of the health assessment; and
- offering the patient a written report on the health assessment.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*

AN.0.43 Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

· An Aboriginal or Torres Strait Islander child who is less than 15 years.

· An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.

· An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

A health assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

MBS item 715 must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient; and

(e) keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the general practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from https://www.health.gov.au/resources/apps-and-tools/the-australian-type-2-diabetes-risk-assessment-tool-ausdrisk.

A health assessment may only be claimed by a general practitioner.

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, "usual doctor" means the general practitioner, or a general practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

The Health Assessment for Aboriginal and Torres Strait Islander People is not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

MBS health assessment item 715 must be provided by a general practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist general practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the general practitioner. This may include activities associated with:

- information collection; and

- providing patients with information about recommended interventions at the direction of the general practitioner.

The general practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

General practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Item 715 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 715 can be claimed for services provided by general practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of item 10990 and 10991 are satisfied.

The Health Assessment for Aboriginal and Torres Strait Islander People may be provided once every 9 months.

AN.0.44 A Health Assessment for an Aboriginal and Torres Strait Islander child (less than 15 years of age)

An Aboriginal and Torres Strait Islander child health assessment must include:

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
    i. mother's pregnancy history;
    ii. birth and neo-natal history:
    iii. breastfeeding history;
    iv. weaning, food access and dietary history;
    v. physical activity;
    vi. previous presentations, hospital admissions and medication usage;
    vii. relevant family medical history;
    viii. immunisation status;
    ix. vision and hearing (including neonatal hearing screening);
    x. development (including achievement of age appropriate milestones);
    xi. family relationships, social circumstances and whether the person is cared for by another person;
    xii. exposure to environmental factors (including tobacco smoke);
    xiii. environmental and living conditions;
    xiv. educational progress;
    xv. stressful life events;
    xvi. mood (including incidence of depression and risk of self-harm);
    xvii. substance use;
    xviii. sexual and reproductive health; and
    xix. dental hygiene (including access to dental services).
c. examination of the patient, including the following:
    i. measurement of height and weight to calculate body mass index and position on the growth curve;
    ii. newborn baby check (if not previously completed);
    iii. vision (including red reflex in a newborn);
    iv. ear examination (including otoscopy);
    v. oral examination (including gums and dentition);
    vi. trachoma check, if indicated;
    vii. skin examination, if indicated;
    viii. respiratory examination, if indicated;
    ix. cardiac auscultation, if indicated;
    x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;
    xi. assessment of parent and child interaction, if indicated; and
    xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.
d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:
    i. haemoglobin testing for those at a high risk of anaemia; and
    ii. audiometry, if required, especially for those of school age

e. assessing the patient using the information gained in the child health check; and
f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

AN.0.45 A health assessment for an Aboriginal and Torres Strait Islander adult (aged between 15 years and 54 years)

An Aboriginal and Torres Strait Islander adult health assessment must include:

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
    i. current health problems and risk factors;
    ii. relevant family medical history;
    iii. medication usage (including medication obtained without prescription or from other doctors);
    iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;
    v. sexual and reproductive health;
    vi. physical activity, nutrition and alcohol, tobacco or other substance use;
    vii. hearing loss;
    viii. mood(including incidence of depression and risk of self-harm); and
    ix. family relationships and whether the patient is a carer, or is cared for by another person;
    x. vision
c. examination of the patient, including the following:
    i. measurement of the patient's blood pressure, pulse rate and rhythm;
    ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;
    iii. oral examination (including gums and dentition);
    iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and
    v. urinalysis (by dipstick) for proteinurea;
    vi. eye examination; and
d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):
    i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;
    ii. cervical screening;
    iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and
    iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).
e. assessing the patient using the information gained in the adult health assessment; and
f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment;

AN.0.46 A health assessment for an Aboriginal and Torres Strait Islander older person (aged 55 years and over)

An Aboriginal and Torres Strait Islander Older Person's health assessment must include:

a. a personal attendance by the general practitioner;
b. measurement of the patient's blood pressure, pulse rate and rhythm;
c. an assessment of the patient's medication;
d. an assessment of the patient's continence;

e. an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
f. an assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3months;
g. an assessment of the patient's psychological function, including the patient's cognition and mood;
h. an assessment of the patient's social function, including:
    i. the availability and adequacy of paid, and unpaid, help;
    ii. whether the patient is responsible for caring for another person;
i. an eye examination

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with
c. recommendations on matters covered by the health assessment; and
d. offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

AN.0.47 Chronic Disease Management Items (Items 721 to 732)

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

* CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Patients with a mental health condition being treated under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS)* (Better Access) initiative or under an Eating Disorder Treatment and Management Plan (EDTMP) are also eligible to receive a TCA service. However, the general practitioner should consider whether it would be more appropriate to review any existing TCA rather than develop a new one specifically for the patient's mental health condition.

Regulatory requirements

Items 721, 723, 729, 731 and 732 provide rebates to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Items 723 and 732 also provide rebates to manage mental health conditions by coordinating the development or review of TCAs. They apply for a patient who is being treated under the Better Access initiative or has an EDTMP.

Treated under the Better Access initiative means a patient has been referred for a:

- a focussed psychological strategies service delivered by a GP, OMP, psychologist, social worker or occupational therapist, or

- psychological therapy service delivered by a clinical psychologist

Please note: TCAs do not constitute a referral. A referral is still required to access allied mental health services.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 123, 124, 151, 165, 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 585, 588, 591, 594, 599, 600, 733, 737, 741, 745, 761, 763, 766, 769, 2197, 2198, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5071, 5076, 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228, 5261, 91790, 91792, 91794, 91800, 91801, 91802, 91803, 91804, 91805, 91806, 91807, 91808, 91890, 91891, 91892, 91893, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923, 91926, 92210 and 92211 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Patient eligibility

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

CDM items 721, 723 and 732

These are:

· available to:

i. patients in the community; and
ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

· not available to:

i. public in-patients of a hospital; or
ii. care recipients in a residential aged care facility.

CDM item 729

This is:

· available to:

i. patients in the community;
ii. both private and public in-patients being discharged from hospital.

· not available to care recipients in a residential aged care facility.

CDM item 731

This item is available to care recipients in a residential aged care facility only.

Item 721

A comprehensive written plan must be prepared describing:

a. the patient's health care needs, health problems and relevant conditions;
b. management goals with which the patient agrees;
c. actions to be taken by the patient;
d. treatment and services the patient is likely to need;
e. arrangements for providing this treatment and these services; and
f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:

a. explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
b. record the plan; and
c. record the patient's agreement to the preparation of the plan; and
d. offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
e. add a copy of the plan to the patient's medical records.

A copy of the written plan must be retained for 2 years.

Item 723

When coordinating the development of Team Care Arrangements (TCAs), the general practitioner must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and
b. prepare a document that describes:
    i. treatment and service goals for the patient;
    ii. treatment and services that collaborating providers will provide to the patient; and
    iii. actions to be taken by the patient;
    iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and
c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and
e. record the patient's agreement to the development of TCAs;
f. give copies of the relevant parts of the document to the collaborating providers;
g. offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
h. add a copy of the document to the patient's medical records.

The document described above must be retained for 2 years.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 729

A multidisciplinary care plan means a written plan that:

a. is prepared for a patient by:
    i. a general practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or
    ii. a collaborating provider (other than a general practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

A copy of the written plan must be retained for 2 years.

Item 731

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a general practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to 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 735 to 758 apply).

Item 732

An "associated general practitioner" is a general practitioner who, if not engaged in the same general practice as the general practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the general practitioner must:

a. explain to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) the steps involved in the review;
b. record the patient's agreement to the review of the plan;
c. review all the matters set out in the relevant plan;
d. make any required amendments to the patient's plan;
e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
f. add a copy of the amended document to the patient's records; and
g. provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the general practitioner must:

a. explain the steps involved in the review to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
b. record the patient's agreement to the review of the TCAs or plan;
c. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the general practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;
d. make any required amendments to the patient's plan;
e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
f. provide for further review of the amended plan by a date specified in the plan;
g. give copies of the relevant parts of the amended plan to the collaborating providers; and
h. add a copy of the amended document to the patient's records.

A copy of the amended plan must be retained for 2 years.

Item 732 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan (former item 720) or to COORDINATE REVIEW OF A Discharge Care Plan (former item 722), where these services were coordinated or prepared by that general practitioner (or an associated general practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 732 can be claimed twice on the same day - for example for reviewing a GP Management Plan and another for reviewing Team Care Arrangements (TCAs) provided both are delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

· **Non electronic Medicare claiming of items 732 on the same date**
The time that each item 732 commenced should be indicated next to each item

· **Electronic Medicare claiming of item 732 on the same date**
Medicare Easyclaim*:* use the 'ItemOverrideCde" set to 'AP', which flags the item as *not duplicate services*
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate*

Items 721, 723 and 732

The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Items 721-732 should generally be undertaken by the patient's **usual general practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

· individual allied health services (items 10950 to 10970); and/or

· group allied health services (items 81100 to 81125).

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

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

Services Australia has published the following guidelines to assist medical practitioners: Chronic disease GP Management Plans and Team Care Arrangements.

AN.0.48 Medicare Dental Items For Patients With Chronic Conditions And Complex Care Needs - Services Provided By A Dental Practitioner On Referral From A GP [Items 85011-87777]

Closure of Medicare Dental Items 85011-87777

The Medicare Chronic Disease Dental Scheme closed on 30 November 2012. No Medicare benefits will be payable for any dental services provided under Medicare dental items 85011-87777 provided after this date. The cost of any future dental services will need to be met by the patient.

Further details regarding the closure are available at www.health.gov.au/dental.

AN.0.49 Multidisciplinary Case Conferences by General Practitioners - (Items 735 to 758)

Items 735 to 758 provide rebates for general practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items **735, 739 and 743**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

(b) record the patient's agreement to the conference; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items **747, 750 and 758**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the general practitioner's participation in the conference; and

(b) record the patient's agreement to the general practitioner's participation; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual general practitioner

Items 735-758 should generally be undertaken by the patient's usual general practitioner. This is a general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information

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

AN.0.50 Public Health Medicine - (Items 410 to 417)

Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following: -

(i) management of a patient's vaccination requirements for accepted immunisation programs; or

(ii) prevention or management of sexually transmitted disease; or

(iii) prevention or management of disease due to environmental hazards or poisons; or

(iv) prevention or management of exotic diseases; or

(v) prevention or management of infection during outbreaks of infectious disease.

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

AN.0.51 Case Conferences by Consultant Physician - (Items 820 to 838, 6029 to 6034 and 6064 to 6075)

Items 820, 822, 823, 825, 826, 828, 6029, 6031, 6032, 6034, 6064, 6065, 6067, 6068, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 apply to a community case conference (including a case conference conducted in a residential

aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Community case conference items ie 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital.

For items 830, 832, 834, 835, 837 and 838, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A case conference is a process by which a multidisciplinary team carries out the following activities:

-discusses a patient's history;

-identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

-identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and

-assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor their informal carer can be counted toward the minimum of four. One member may be another medical practitioner.

For the purposes of items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor their informal carer can be counted toward the minimum of three. One member may be another medical practitioner.

In addition to the consultant physician and one other medical practitioner, "formal care providers" include:

-allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and

-community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

For items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether they agree to the case conference taking place; and

(b) recording the patient's or agent's agreement to the case conference; and

(c) recording the day on which the conference was held, and the times at which the conference started and ended; and

(d) recording the names of the participants; and

(e) putting a copy of that record in the patient's medical records; and

(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and

(h) giving a copy of the summary of the conference to the patient's usual general practitioner; and

(i) discussing the outcomes of the patient or the patient's agent.

Organisation of a discharge case conference (items 830, 832 and 834), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care.

Participation in a case conference

For items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074, 6075. participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a)recording the day on which the conference was held, and the times at which the conference started and ended; and

(b) recording the matters mentioned in **Organisation of a case conference** in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

General requirements

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for participating in a case conference or four care providers for organising a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

-Inform the patient that their medical history, diagnosis and care preferences will be discussed with other case conference participants;

- Provide an opportunity for the patient to specify what medical and personal information they want to be conveyed to, or withheld from, the other care providers;

-Inform the patient that they will incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with items 735 to 758 (GPs), and items 235 to 244 (non-specialist practitioners).

The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See General Explanatory Notes for further details on billing procedures.

It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.0.52 Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR's are targeted at patients who are:

· currently taking five or more regular medications;

· taking more than 12 doses of medication per day;

· have had significant changes made to medication treatment regimen in the last three months;

· taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;

· experiencing symptoms suggestive of an adverse drug reaction;

· displaying sub-optimal response to treatment with medicines;

· suspected of non-compliance or inability to manage medication related therapeutic devices;

· having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;

· attending a number of different doctors, both general practitioners and specialists; and/or

· recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, general practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

· Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;

· Is subject to a chronic condition and/or complex medication regimen; and

· Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the general practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a general practitioner must, with the patient's consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

A DMMR includes all DMMR-related services provided by the general practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 900 may be claimed.

If the general practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the general practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual general practitioner. This is the general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient

over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the general practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of **referral to a community pharmacy or an accredited pharmacist** includes:

· Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

· Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the general practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

· A DMMR referral form is available for this purpose. If this form is not used, the general practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The **discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist** includes:

· Receiving a written report from the reviewing pharmacist; and

· Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and

· Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of **a written medication management plan following discussion with the patient** includes:

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

Item 903 - Residential Medication Management Review

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility

RMMRs are available to:

new residents on admission into a RACF; and

existing residents on an 'as required' basis, where in the opinion of the resident's general practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A general practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and general practitioner agree that issues arising out of the review should be considered in a case conference.

A RMMR comprises all activities to be undertaken by the general practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

· any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;

· any subsequent follow up should be treated as a separate consultation item;

· an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the general practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the general practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual GP'. This is the general practitioner, or a general practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable time-frame. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's general practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The general practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The general practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

Related Items: **900 903**

AN.0.56 GP Mental Health Treatment Items

This note provides information on the GP Mental Health Treatment items 2700, 2701, 2712, 2713, 2715 and 2717, and is also applicable for video and phone equivalent MBS items 92112, 92113, 92114, 92115, 92116, 92117, 92126 and 92127. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

The GP Mental Health Treatment items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296, 297, 299 and 92437), clinical psychologists (items 80000, 80005, 80010, 80015, 91166, 91167, 91181 and 91182) and allied mental health providers (items 80100, 80105, 80110, 80115, 80125, 80130, 80135, 80140, 80150, 80155, 80160, 80165, 91169, 91170, 91172, 91173, 91175, 91176, 91183, 91184, 91185, 91186, 91187 and 91188).

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services;
- review and ongoing management as required.

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by general practitioner. The term 'GP' is used in these notes as a generic reference to general practitioners able to claim these items.

Training Requirements (items 2715, 2717, 92116 and 92117)

GPs providing Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715, 2717, 92116 and 92117. For GPs who have not undertaken training, items 2700, 2701, 92112 and 92113 are available. Items 2700, 2715, 92112 and 92116 provides for a Mental Health Treatment Plan lasting at least 20 minutes and item 2701, 2717, 92113 and 92117 provides for a Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items.

What patients are eligible - Mental Disorder

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

These GP services are available to eligible patients in the community. GP Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the service is provided as part of an episode of hospital

treatment it must be claimed at the 75% MBS rebate. GPs are able to contribute to care plans for patients using item 729, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 731 or 92027.

PREPARING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2700, 2701, 2715,2717, 92112, 92113, 92116 or 92117)

What is involved - Assess and Plan

A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the general practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

Assessment

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Treatment Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117.

In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Preparation of a GP Mental Health Treatment Plan

In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focussed

psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117 a patient is eligible to be referred for up to 10 Medicare rebateable mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies). Please note group therapy does not include family and couples therapy.

When referring patients GPs should provide the information outlined under the 'Referral' heading below. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP.

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712, 92114 or 92126).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2712, 92114 or 92126)

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

A rebate can be claimed once the GP who prepared the patient's GP Mental Health Treatment Plan (or another GP in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Treatment Plan by completing the activities that must be included in a review and meeting the relevant requirements listed under 'Additional Claiming Information'. The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291 or 92435), as if that patient had a GP Mental Health Treatment Plan.

The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- modification of the documented GP Mental Health Treatment Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of ongoing management.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item.

GP MENTAL HEALTH TREATMENT CONSULTATION - (Item 2713, 92115 or 92127)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services. This does not include referral for Medicare rebateable services for focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291 or 92435).

Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a GP is managing a patient under a referred psychiatrist assessment and management plan, a patient is eligible for up to 10 Medicare rebateable individual mental health services per calendar year by:

- clinical psychologists providing psychological therapies; or
- appropriately trained GPs or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy, in line with their clinical need. Please note group therapy does not include family and couples therapy.

When preparing a patient’s Mental Health Treatment Plan and making a referral GPs should speak to the patient about their treatment needs and the type of treatment, for example individual and/or group sessions, that might be suitable for their particular circumstances.

Please note if a referral does not specify whether it relates to individual or group therapy, the patient can use a referral to access either or both individual and group therapy treatment options.

A referral for mental health services should be in writing (signed and dated by the GP) and include:

- the patient’s name, date of birth and address;
- the patient’s symptoms or diagnosis, including whether a GP Mental Health Treatment Plan has been completed for the patient;

- a list of any current medications;
- the number of sessions the patient is being referred for (the 'course of treatment');
- a statement about whether the patient has a mental health treatment plan or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered.

Where appropriate, and with the patient's agreement, the GP can also attach a copy of the mental health treatment plan to the referral.

Including these details on a referral will assist with any auditing undertaken by the Department of Health and Aged Care.

Number of Sessions

The GP can decide how many sessions the patient will receive in a course of treatment, within the maximum session limit for the course of treatment. The maximum session limit for each course of treatment is set out below:

- Initial course of treatment – a maximum of six sessions.
- Subsequent course of treatment – a maximum of six sessions up to the patient's cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

The GP should consider the patient's clinical need for further sessions after each course of treatment, including through considering the written report provided by the treating practitioner. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the maximum number of services available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Specifying the Number of Sessions in a Referral

If the GP:

- Does not specify the number of sessions
- Specifies a number of sessions above the maximum allowed for the course of treatment
- Specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year)

Then the treating practitioner can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of sessions allowed for that particular course of treatment (as set out above), and
- the maximum number of sessions allowed in a calendar year.

The treating practitioner must still provide a report at the end of a course of treatment in line with standard practice for these services. The referring medical practitioner should therefore consider the treating practitioner's report on the services provided to the patient, and the need for further treatment.

Verbal Referral

A GP can verbally refer a patient for Better Access services only if:

- in their clinical judgement they consider it is necessary for the patient to have immediate access to support from an allied mental health professional, and
- it is not practicable in the circumstances to provide a written referral – for example, to do so would cause delays in treatment to the patient's detriment, and
- the allied mental health professional documents in writing that they are treating the patient based on the GP's verbal referral, and
- the GP provides a written referral to the allied mental health professional as soon as possible afterwards.

While waiting for the referring practitioner to provide a written referral, the treating practitioner can provide treatment according to the verbal referral until the referred number of sessions have been completed. If there is any doubt about the number of sessions the patient was verbally referred for, the treating practitioner should follow the guidance provided above under the heading 'Specifying the Number of Sessions in a Referral'.

A verbal referral does not replace the requirement for the GP to review the patient's progress (taking into account the written report from their treating allied health professional) after each course of treatment.

Referrals for the Additional 10 Sessions (available until 31 December 2022)

In response to the COVID-19 pandemic, the number of Medicare rebateable individual mental health services was temporarily increased from 10 to 20 per calendar year until 31 December 2022.

A patient does not need a new referral to access Better Access sessions from 1 January 2023. If the patient has a current referral (either for the initial 10 sessions or the additional 10 sessions) and has not used all of the sessions, they can use that referral to access sessions in 2023. However, they cannot receive more than 10 individual sessions in 2023.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the GP must ensure that:

- the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and
- the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a benefit for that service, the GP must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The GP may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and
- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where an additional consultation is undertaken, both services must be clinically relevant and all item requirements must be met. For example, for item 2700, the duration of the service must have been at least 20 minutes. The time of the preceding consultation must not be counted towards the time of the mental health service.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

Links to other Medicare Services

It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the new GP Mental Health Treatment items.
- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.
- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

AN.0.57 Provision of Focussed Psychological Strategies - (Items 2721, 2723, 2725, 2727, 91818, 91819, 91842 and 91843)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan or a psychiatrist assessment and management plan.

Minimum Requirements

All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with Services Australia as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 2721, 2723, 2725, 2727, 91818, 91819, 91842 and 91843 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 mental health services under these item numbers per calendar year. The 10 services may consist of: GP focussed psychological strategies services (items 2721, 2723, 2725, 2727; 91818, 91819, 91842 and 91843) or non-specialist medical practitioner items (283, 285, 286, 287, 91820, 91821, 91844 and 91845); and/or psychological therapy services (items 80000, 80005, 80010, 80015, 91166,

91167, 91181 and 91182); and/or focussed psychological strategies – allied mental health services (items 80100, 80105, 80110, 80115, 80125, 80130, 80135, 80140, 80150, 80155, 80160, 80165, 91169, 91170, 91172, 91173, 91175, 91176, 91183, 91184, 91185, 91186, 91187 and 91188).

Out-of-Surgery Consultation

It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

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

6. Eye-Movement Desensitisation Reprocessing (EMDR)

Mental Disorder

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

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

AN.0.58 Pain and Palliative Medicine (Items 2801 to 3093)

Attendance by a recognised specialist or consultant physician in the specialty of pain medicine (2801, 2806, 2814, 2824, 2832, 2840) and Case conference by a recognised specialist or consultant physician in the specialty of pain medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).

Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, apply only to a service provided by a recognised specialist or consultant physician in the specialty of pain medicine, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note AN.0.51 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of pain medicine and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

Attendance by a recognised specialist or consultant physician in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028) and Case conference by a recognised specialist or consultant physician in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).

Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, apply only to a service provided by a recognised specialist or consultant physician in the specialty of palliative medicine, in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

General Practitioners who are recognised specialist in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 732) or Team Care Arrangement items (723 and 732) for that patient. The referring practitioner is able to provide these services.

The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note AN.0.51 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of palliative medicine and that service is a palliative medicine service, then the relevant items from the palliative specialist group 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

AN.0.60 Attendances by Medical Practitioners who are Emergency Physicians - (Items 5001 to 5036)

Items 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 and 5019 under Group A21 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the Australasian College for Emergency Medicine (ACEM).

Other than for point-of-care ultrasound (see below), only modifying add-on therapeutic and procedural items under Subgroup 14 in Group T1 may be claimed in conjunction with attendance items 5001 to 5019.

Items relating to point-of-care ultrasound services are not separately payable from emergency attendance items 5001 to 5019 where performed for a reason that represents routine use as standard of care in an Emergency Department attendance. For example, the following four (non-exhaustive) reasons:

a. To identify nerves for the purposes of administering nerve blocks.
b. To identify vessels, including abdominal aortic aneurysms.
c. As part of a focused assessment with sonography for trauma (FAST) scan.

Where the “standard of care” principle does not apply, items relating to point-of-care ultrasound services are payable in addition to emergency attendance items 5001 to 5019, where the following three criteria are met:

a. A formal report is provided and is stored in a manner that reasonably facilities future retrieval / access.
b. The images are stored in a manner that reasonably facilitates future retrieval / access.

c. The provider is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of ultrasound services.

For the sake of clarity, hospitals do not constitute recognised bodies for the credentialing of ultrasound services. The ACEM has published policy on the appropriate credentialing for Emergency Medicine ultrasonography, such as the "Policy on Credentialing for Emergency Medicine Ultrasonography". As noted by ACEM, examples of appropriate credentials include the Diploma in Diagnostic Ultrasound (DDU) and the Certificate in Clinician Performed Ultrasound (CCPU) offered by the Australasian Society for Ultrasound in Medicine (ASUM).

Emergency Attendance Categories

Items 5001 to 5019 cover three categories of attendance to reflect the differing categories of professional involvement required during emergency attendances undertaken in a recognised emergency medicine department of a private hospital, based on the number of differential diagnoses and comorbidities that require consideration rather than simply on the time spent with the patient. The emergency department must be part of a private hospital and this department must be licensed as a "recognised emergency department" by the appropriate State or Territory government authority.

Mirror emergency attendance items (items 5021 to 5036) are provided for medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency attendances, regardless of provider type (see notes below under 'Emergency Medicine Attendances by Medical Practitioners who are not Emergency Physicians').

A new subgroup of therapeutic and procedural add-on items is provided under Subgroup 14 in Group T1 of the MBS for services most commonly performed in emergency medicine (for example, fractures and resuscitation). These items are to be claimed in conjunction with attendances on patients by emergency physicians (items 5001 to 5019) or medical practitioners (5021 to 5036). Explanatory notes for Group T1, Subgroup 14 items are provided in TN.1.22.

The following notes in respect of the three categories are provided to assist emergency physicians and medical practitioners in selecting the appropriate attendance item number for Medicare benefit purposes. The essential difference between the three attendance categories relate not to time but to complexity.

It is recognised that change of shift handovers are common occurrences within the emergency care setting. Emergency physicians and medical practitioners assuming responsibility of care for patients from the first practitioner may bill the attendance items based on the level of complexity and engagement appropriate to the patient's care.

The attendances for items 5001 to 5019 (and non-emergency physician items 5021 to 5036) are divided into three categories relating to the level of complexity involved in medical decision-making, namely:

a. Ordinary complexity
b. Complexity that is more than ordinary but not high
c. High complexity

Age modifiers have been applied to each category of attendance to reflect the level of additional complexity and professional involvement, namely:

a. Aged 4 years or over but under 75 years
b. Aged under 4 years
c. Aged 75 years or over

Ordinary Complexity

These items are for the consultation, investigation (if required) and management of a single system issue in a patient with no relevant comorbidities where the differential diagnosis is limited.

Includes targeted history and examination, interpretation of relevant investigations (if required), development and initiation of a management plan, relevant GP and specialist communication and associated documentation. These patients would typically be discharged home from the Emergency Department. A period of observation is not required for these patients.

Complexity More than Ordinary but Not High

These items are for the assessment, investigation and management of an undifferentiated presentation or a presentation with a clear diagnosis that needs risk stratification and complication exclusion. Where the diagnosis is clear from the outset, this item should be used when management is time consuming or more than one strategy is required. The attendance may include referral or consultation with alternate specialist(s). These patients may or may not be admitted.

Includes a period of observation in response to initial treatment and / or requiring results of investigations to inform an ongoing management plan, and includes any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

For patients requiring a prolonged period of observation, admission to an emergency department short stay unit may be required.

High Complexity

These items are for the assessment, investigation and management of an undifferentiated ED patient with one or more comorbidities and more than one differential diagnosis.

These items may include time consulting with alternate specialists, liaising with community services and arrangement of admission, pharmacy reconciliation, communication with family, carers and general practitioners; and any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

For patients requiring a prolonged period of observation, admission to an emergency department short stay unit may be required.

Related Items: 5001 5004 5011 5012 5013 5014 5016 5017 5019

Emergency Medicine Attendances by Medical Practitioners who are not Emergency Physicians (Items 5021 to 5036)

Mirror items (5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 and 5036) are provided for emergency medicine attendance services performed by medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency attendances, regardless of provider type.

The mirror items reflect the emergency physician items and are divided into three categories relating to the level of complexity with age modifiers applied to each attendance category.

Related Items: 5021 5022 5027 5030 5031 5032 5033 5035 5036

AN.0.61 Emergency Medicine Attendances for the provision of Goals of Care (Items 5039, 5041, 5042 and 5044)

Items 5039 and 5041 are for goals of care services, performed by emergency physicians to support gravely ill patients to make informed decisions regarding treatment of their medical condition.

Mirror items (5042 and 5044) are for the provision of goals of care by medical practitioners who are not emergency physicians.

Items 5039 for emergency physicians and 5042 for medical practitioners are for goals of care services to be performed in conjunction with, or after, the new emergency medicine attendance services (items 5001 to 5036). It is expected the doctor would have performed the emergency attendance service on the patient and would be familiar with the patient's medical issues and circumstances.

Items 5041 for emergency physicians and 5044 for medical practitioners are for goals of care services that are not performed in conjunction with, or after, the new emergency medicine attendance services (items 5001 to 5036). These items are for situations where the doctor would not be familiar with the patient's medical issues and circumstances and the attendance is for at least 60 minutes.

Notes:

The conditions to be met before services covered by items 5039, 5041, 5042 and 5044 attract benefits are provided under the following definitions of "gravely ill patient lacking goals of care" and "preparation of goals of care" in the GMST.

"gravely ill patient lacking current goals of care" means a patient to whom all of the following apply:

(a) the patient either:

(i) is suffering a life-threatening acute illness or injury; or

(ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months;

(b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;

(c) either:

(i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or

(ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

"preparation of goals of care" for a patient, by a medical practitioner, means the carrying out of all of the following activities by the practitioner:

(a) comprehensively evaluating the patient's medical, physical, psychological and social issues;

(b) identifying major issues that require goals of care for the patient to be set;

(c) assessing the patient's capacity to make decisions about goals of care for the patient;

(d) discussing care of the patient with the patient, or a person (the surrogate) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:

(i) members of the patient's family;

(ii) other persons who provide care for the patient;

(iii) other health practitioners;

(e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;

(f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;

(g) recording the agreed goals so that:

(i) the record can be readily retrieved by other providers of health care for the patient; and

(ii) interventions that should, or should not, be made in care of the patient are identified.

Patients could be assessed for "a life-threatening acute illness or injury" (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the Supportive and Palliative Care Indicators Tool (SPICTTM).

"offering reasonable options for care" means that the patient must be provided with reasonable alternatives to continued intensive/active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).

"recording the agreed goals" should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.

Patients with existing goals of care plans are eligible if such records cannot be readily retrieved by the medical practitioners; or if their condition has changed to the point the record does not reflect the patient's current medical condition and it is reasonable for new goals of care to be developed.

Providers of goals of care services should be appropriately trained to provide end-of-life care options and goals of care discussions.

Items 5039, 5041, 5042 and 5044 should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.

Related Items: 5039 5041 5042 5044

AN.0.62 Case Conferences by Consultant Psychiatrists - (Items 855 to 866)

A range of items are available for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and make it easier for psychiatrists to work with general practitioners and allied health professionals, thereby ensuring better coordinated care for patients. Three new items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner are counted towards the minimum of three.

Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital.

For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 861, 864 or 866 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;

- identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and can include the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team, in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

For the purposes of items 855 to 866 a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

In addition to the consultant psychiatrist and one other medical practitioner, "formal care providers" include:

- allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

- home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The involvement of a patient's carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The involvement of the patient's carer is not counted towards the minimum of three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

Organisation of a case conference

Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

- explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and

- recording the patient's agreement to the case conference; and

- recording the day on which the conference was held, and the times at which the conference started and ended; and

- recording the names of the participants; and

- recording the matters mentioned in AN.0.51 and putting a copy of that record in the patient's medical records; and

- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and

- discussing the outcomes of the case conference with the patient.

General requirements

It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that their medical history, diagnosis and care preferences will be discussed with other care providers;

- Provide an opportunity for the patient to specify what medical and personal information they want to be conveyed to or withheld from the other case conference team members; and

- Inform the patient that they will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.

- Inform the patient of any additional costs they will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided.

AN.0.63 Case Conference by Consultant Physicians in Geriatric/Rehabilitation Medicine - (Item 880)

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

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

· rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

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

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

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and

- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

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

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

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

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

AN.0.64 Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015)

Referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

The neurosurgical consultation structure comprises an initial consultation (item 6007) and four categories of subsequent consultations (items 6009-6015). These categories relate to the time AND level of complexity of the attendance i.e

(i) Level 1 - 6009

(ii) Level 2 - 6011

(iii) Level 3 - 6013

(iv) Level 4 - 6015

The following provides further guidance for neurosurgeons in utilising the appropriate items in common clinical situations:

(i) Initial consultation item 6007 will replace item 104.

(ii) Subsequent consultation items 6009-6015 will replace item 105

Item 6009 (subsequent consultation on a patient for 15 mins or less) covers a minor subsequent attendance which is straightforward in nature. Some examples of a minor attendance would include consulting with the patient for the purpose of issuing a repeat script for anticonvulsant medications or the routine review of a patient with a ventriculo-peritoneal shunt.

Item 6011 (subsequent consultation on a patient for a duration of between 16 to 30 mins) would involve an detailed and comprehensive examination of the patient which is greater in complexity than would be provided under item 6009, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record included in the patient notes. Some examples of a detailed neurosurgical attendance would include:

· the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningiomaglioma, spinal cord tumour);

· consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or

· consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve a extensive and comprehensive examination of the patient greater in complexity than under item 6011, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Item 6013 would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record be included in the patient notes. Some examples of an extensive neurosurgical attendance would include:

· an attendance on a patient prior to a craniotomy for cerebral tumour;

· surgery for spinal tumour;

· revision of spinal surgery;

· epilepsy surgery; or

· for the treatment of cerebral aneurysm.

Examination of such patients would include full cranial nerve examination or examination of upper and lower limb nervous system.

Item 6015 (subsequent consultation on a patient with complex neurological conditions for a duration of more than 45 mins) should involve an exhaustive examination of the patient that is more comprehensive than 6013 and any ordering or evaluation of investigations and include detailed relevant patient notes. It would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is thoroughly discussed with the patient and a written record be included in the patient notes. An exhaustive neurosurgical consultation includes:

· managing adverse neurological outcomes;

· detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or

· discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

Examination of such patients would include exhaustive neurosurgical examination including full neurological examination (cranial nerves and limbs) or detailed 'focused examination' (e.g.: brachial plexus examination)

Complex neurosurgical problems referred to in items 6013 and 6015 include:

· deterioration in neurologic function following cranial or spinal surgery;

· presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or

· chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

NOTE: It is expected that informed financial consent be obtained from the patient where possible.

AN.0.65 Cancer Care Case Conference - (Items 871 and 872)

For the purposes of these items:

· private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;

· the billing general practitioner, specialist or consultant physician may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item.

· only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.

· each billing practitioner must ensure that their patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;

· participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;

· suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;

· in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and

· cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.

AN.0.66 Non-directive Pregnancy Support Counselling Service - (Item 4001)

Overview

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is:

· pregnant; or

· who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

Item 4001 - services provided by an eligible GP. The term 'GP' is used hereafter as a generic reference to general practitioners;

Item 792 – services provided by an eligible medical practitioner (not including a specialist or consultant physician)

Item 81000 - services provided by an eligible psychologist;

Item 81005 - services provided by an eligible social worker; and

Item 81010 - services provided by an eligible mental health nurse.

This notes relate to provision of a non-directive pregnancy support counselling service by an eligible GP.

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the GP undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 4001 are available to a person who is:

- pregnant; or
- who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 792, 4001, 81000, 81005 and 81010.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Services Australia on 132 011. Alternatively, the GP may check with Services Australia (although the patient must be present to give permission).

Item 10990 or item 10991 can also be claimed in conjunction with item 4001 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

Minimum Requirements

This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training.

AN.0.69 Time-Tiered Health Assessment - Veterans' Health Assessment

Publication date: 1 July 2024

SUMMARY

Time tiered health assessment items may be used to undertake a one-off Veterans' Health Assessment for former serving members of the Australian Defence Force (ADF), including former members of permanent and reserve forces.

Annual Veterans' Health Checks are available for certain DVA Veteran Card holders. These health checks are not provided through the MBS. More information on the Annual Veterans' health checks is available from the Department of Veterans' Affairs.

Note: The requirements below must be met in addition to common principles for time tiered health assessment items, contained in AN.0.36.

USE OF ITEMS

The specific requirements of the Veterans' Health Assessment are set out in Clause 2.15.10 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a Veterans Health Assessment must include:

- an assessment of a patient's physical and psychological health and social function, and
- whether health care, education or other assistance should be offered to the patient to improve the patient's physical or psychological health or social function.

The Regulations also state that the health assessment must include taking a history of the patient that includes the following:

- an assessment of the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge
- the patient's social history, including relationship status, number of children (if any) and current occupation
- the patient's current medical conditions, and
- whether the patient suffers from hearing loss or tinnitus
- the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription
- the patient's smoking, if applicable
- the patient's alcohol use, if applicable
- the patient's substance use, if applicable
- the patient's level of physical activity
- whether the patient has bodily pain
- whether the patient has difficulty getting to sleep or staying asleep
- whether the patient has psychological distress
- whether the patient has post-traumatic stress disorder
- whether the patient is at risk of harm to self or others
- whether the patient has anger problems
- the patient's sexual health, and
- any other health concerns the patient has.

Note: The Regulations do not preclude a medical practitioner's consideration of the patient's broader immunisation status, such as for immunisations listed under the National Immunisation Program schedule or for COVID-19, or broader health factors, such as a patient's occupational exposure to biological or chemical substances that may be potentially harmful.

A Veterans Health Check must also include:

- measuring the patient's height
- weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months
- measuring the patient's waist circumference
- taking the patient's blood pressure
- using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary either by:
    - making the further assessment, or
    - or referring the patient to another medical practitioner who can make the further assessment,
- documenting a strategy for improving the patient's health, and
- offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures.

The Veterans Health Assessment may be performed using the ADF *Post-discharge GP Health Assessment Tool* found on the Department of Veterans' Affairs website at: https://www.dva.gov.au/about-us/dva-forms/veteran-health-check-assessment-tool.

ELIGIBLE PATIENTS

Patients eligible for a Veterans' Health Assessments are former members of the Permanent Forces or a former member of the Reserves.

A Veterans' Health Assessment cannot be claimed more than once by an eligible patient.

ELIGIBLE PRACTITIONERS

A Veterans' Health Assessment can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

Patients must access a Veterans' Health Assessment through their usual GP or prescribed medical practitioner. In relation to a patient, means a general practitioner, or a prescribed medical practitioner, employed by a medical practice:

- that has provided at least 50% of the primary health care required by the patient in the last 12 months, or
- that the patient anticipates will provide at least 50% of the patient's primary health care requirements in the next 12 months.

Note: the usual doctor requirements for the Veterans' Health Assessment are different to those applying to health assessments generally.

Information on the definition of usual GP or prescribed medical practitioner for health assessment items is available in AN.0.36.

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with a Veterans' Health Assessment service, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations require that the doctor must keep a record of the assessment.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.70 Limitation of items—certain attendances by specialists and consultant physicians

Medicare benefits are not payable for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009, 6011, 6013, 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618 when claimed in association with an item in group T8 with a schedule fee of $341.75 or more.

The restriction applies when the procedure is performed by the same practitioner, on the same patient, on the same day.

AN.0.71 General practitioner attendances and aftercare

Medical practitioners working in general practice (excluding specialists and consultant physicians) can provide an aftercare service for which patients are eligible to receive a Medicare benefit, providing that practitioner did not complete the initial procedure for which aftercare treatment is being provided.

Routine aftercare that is provided as follow-up care for a procedure, or that is specified as routine aftercare for a procedure in an MBS item, is not eligible to be billed to the MBS when it is provided by the same practitioner who provided the initial service requiring aftercare. Further information on aftercare treatments can be found in explanatory note TN.8.4 and on Services Australia's website.

RELEVANT LEGISLATION

Further details about the legislative requirements for practitioners to be eligible for Medicare benefits when providing aftercare can be found on the Federal Register of Legislation in the *Health Insurance (Subsection 3(5) General Practitioner Post-Operative Treatment) Direction 2017*.

AN.0.72 Attendance services for complex neurodevelopmental disorders (such as autism spectrum disorder)

Intention of this service under item 289 and telehealth equivalent item 92434

Items 289 or telehealth equivalent item 92434 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for neurodevelopmental disorders, which are assessed to be complex and mean that individuals require support across multiple domains.

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a psychiatrist, for individuals under 25 years of age, diagnosed with a complex neurodevelopmental disorder (NDD). The development of the treatment and management plan, follows a comprehensive medical assessment, and provides the opportunity to refer to eligible Allied Health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Eligibility:

In the context of item 289 (or 92434), the diagnosis of a complex neurodevelopmental disorder requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains. **Complexity** is characterised by multi-domain cognitive and functional disabilities, delay or clinically significant impairment.

Neurodevelopmental domains include:

- Cognition
- Language
- Social-emotional development
- Motor skills
- Adaptive behaviour: conceptual skills, practical skills, social skills or social communication skills

Referral pathways:

Early identification of, and intervention for, individuals with complex NDD is important in promoting positive longer term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where neurodevelopmental concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more specialised assessment, they are encouraged to refer to either a consultant paediatrician or psychiatrist for a comprehensive assessment.

Diagnostic Assessment:

The assessment and diagnosis of a complex NDD should be evaluated in the context of both a physical and developmental assessment. The psychiatrist may require a number of separate attendances (through usual time-tiered or subsequent attendance items 296 to 308, 310, 312, 314, 316, 318, 319 to 352, 91827 to 91831 or 91837 to 91839, 92437, 92455 to 92460) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the psychiatrist determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an Allied Health practitioner, they are able to refer the patient to an eligible Allied Health provider from standard attendance items (296 to 308, 310, 312, 314, 316, 318, 319 to 352 or telehealth items 91827 to 91831, 91837 to 91839, 92437, 92455 to 92460).

Whilst Medicare rebates provide for a total of 8 Allied Health assessment services per patient per lifetime, an eligible Allied Health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible Allied Health professional) by the referring psychiatrist, who must agree to the need for any additional Allied Health services prior to the delivery of the remaining 4 Allied Health assessment services.

Eligible Allied Health Assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech Pathologist (MBS item 82005, 93033, 93041)
- Occupational Therapist (82010, 93033, 93041)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to Allied Health practitioners

The psychiatrist can refer to multiple eligible Allied Health practitioners concurrently, but a separate referral letter must be provided to each Allied Health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each Allied Health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 Allied Health Assessment services

Whilst an eligible Allied Health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93040, 93033 or 93041) and considers additional assessment services are required, they must ensure the referring psychiatrist undertakes a review. If the type of review is not specified by the referring psychiatrist an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary Allied Health referral

Eligible Allied Health practitioners are also able to make inter-disciplinary referrals to other eligible Allied Health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring psychiatrist. Whilst they do not require the need for an attendance with the patient (face-to-face or telehealth) by the referring psychiatrist, they do require an agreement from the referring psychiatrist. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through Allied Health referral

In addition to referring to Allied Health practitioners for assistance with formulating a diagnosis, once a psychiatrist makes a complex neurodevelopmental disorder diagnosis, the psychiatrist may require the contribution of an eligible Allied Health practitioner to assist with the development of the Treatment and Management plan (before billing item 289 or 92434).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring psychiatrist should be mindful of this when referring to eligible Allied Health practitioners.

Development of the Treatment and Management Plan

Once the psychiatrist has made a diagnosis of a complex NDD, to complete the item requirements of item 289 or 92434 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of a complex neurodevelopmental disorder, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)
- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identify major treatment goals and important milestones and objectives
    - Recommendation and referral for treatment services provided by eligible Allied Health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to the referring medical practitioner and relevant Allied Health practitioner/s.

Referral for Allied Health Treatment services

Once a treatment and management plan is in place (after item 289 or 92434 has been claimed) the psychiatrist can refer the individual to eligible Allied Health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible Allied Health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech Pathologist (MBS items 82020, 93036, 93044)
- Occupational Therapist (MBS items 82025, 93036, 93044)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 Allied Health Treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent telehealth items. Whilst the psychiatrist can refer to multiple eligible Allied Health practitioners concurrently, a separate referral letter must be provided to each Allied Health practitioner.

The referral should specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS Allied Health Treatment services unless the pre-requisite items (289 or 92434) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring psychiatrist, up to maximum of 10 services), the eligible Allied Health practitioner must provide a written report to the referring psychiatrist, which should include information on the treatment provided, recommendations for future management of the individual's disorder and any advice to caregivers (such as parents, carers, school teachers). This written report will inform the referring psychiatrist's decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

Inconclusive assessment:

Where a patient does not meet the diagnostic threshold of a complex neurodevelopmental disorder and where ongoing medical management is required, patients can be managed through psychiatry attendance items 300-308, 310, 312, 314, 316, 318 or telehealth equivalent items 91827-91831 or 91837-91839.

Examples include where:

- Neurodevelopment assessment is incomplete or inconclusive
- Neurodevelopmental impairment is present in fewer than two domains
- Neurodevelopmental impairment is present in two or more domains, but individuals do not require sufficient support to meet criteria
- Comprehensive, age-appropriate neurodevelopmental assessment is impossible or unavailable (e.g. in infants or young children- particularly those under 6 years of age)

These individuals may be considered "at risk of a complex neurodevelopmental" and require follow-up and reassessment in the future.

AN.0.73 Attendance services for eligible disabilities

Intention and eligibility of this service under item 139 and telehealth equivalent item 92142

Items 139 or telehealth equivalent item 92142 are intended for diagnosis and treatment for patients under 25 years of age with an eligible disability by a general practitioner.

Definition of Eligible Disabilities is found AR.29.1

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a general practitioner, for individuals under 25 years of age, diagnosed an eligible disability. The development of the treatment and management plan, follows a comprehensive medical assessment, and provides the opportunity to refer to eligible Allied Health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82015, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Diagnostic Assessment:

Early identification of, and intervention for, individuals with eligible disabilities is important in promoting positive longer term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

The assessment and diagnosis of an eligible disability should be evaluated in the context of both a physical and developmental assessment. The GP may require a number of separate attendances (through usual time-tiered or subsequent attendance items 3 to 51 or telehealth items 91790, 91800 to 91802, 91890 and 91891) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the GP may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the GP determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an Allied Health practitioner, they are able to refer the patient to an eligible Allied Health provider from standard attendance items 3 to 51 or telehealth items 91790, 91800 to 91802, 91890 and 91891.

Whilst Medicare rebates provide for a total of 8 Allied Health assessment services per patient per lifetime, an eligible Allied Health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible Allied Health professional) by the referring GP, who must agree to the need for any additional Allied Health services prior to the delivery of the remaining 4 Allied Health assessment services.

Eligible Allied Health Assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech Pathologist (MBS item 82005, 93033, 93041)
- Occupational Therapist (82010, 93033, 93041)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to Allied Health practitioners

The GP can refer to multiple eligible Allied Health practitioners concurrently, but a separate referral letter must be provided to each Allied Health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each Allied Health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 Allied Health Assessment services

Where an eligible Allied Health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040, or 93041) and considers additional assessment services are required, they must ensure the referring GP undertakes a review. If the type of review is not specified by the GP, an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary Allied Health referral

Eligible Allied Health practitioners are also able to make inter-disciplinary referrals to other eligible Allied Health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring GP. Whilst they do not require the need for an attendance with the patient (face-to-face or telehealth) by the referring GP, they do require an agreement from the referring GP. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through Allied Health referral

In addition to referring to Allied Health practitioners for assistance with formulating a diagnosis, once the GP makes a diagnosis, the GP may require the contribution of an eligible Allied Health practitioner to assist with the development of the Treatment and Management plan (before billing item 139 or 92142).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring GP should be mindful of this when referring to eligible Allied Health practitioners.

Development of the Treatment and Management Plan

Once the GP has made a diagnosis of an eligible disability, to complete the item requirements of item 139 or 92142 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of an eligible disability, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)
- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which:
    - Recommendations using a biopsychosocial model
    - Identify major treatment goals and important milestones and objectives
    - Recommendation and referral for treatment services provided by eligible Allied Health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to relevant Allied Health practitioner/s.

Referral for Allied Health Treatment services

Once a treatment and management plan is in place (after item 139 or 92142 has been claimed) the GP can refer the individual to eligible Allied Health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible Allied Health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech Pathologist (MBS items 82020, 93036, 93044)
- Occupational Therapist (MBS items 82025, 93036, 93044)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 Allied Health Treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent telehealth items. Whilst the GP can refer to multiple eligible Allied Health practitioners concurrently, a separate referral letter must be provided to each Allied Health practitioner.

The referral should specify the goals of the treatment and if appropriate, the specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS Allied Health Treatment services unless the pre-requisite items (139 or 92142) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring GP, up to maximum of 10 services), the eligible Allied Health practitioner must provide a written report to the referring GP, which should include information on the treatment provided, recommendations on future management of the individual's disorder and any advice to caregivers (such as parents, carers, schoolteachers). This written report will inform the referring GPs decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

AN.0.74 General Attendance Items - General Practitioners

GENERAL ATTENDANCE ITEMS – GENERAL PRACTITIONERS

	Level A Straightforward	**Level B 6-20 minutes**	**Level C 20+ minutes**	**Level D 40+ minutes**	**Level E 60+ minutes**
Business hours					
In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124
RACF[1]	90020	90035	90043	90051	90054
After-hours					
In consulting rooms[2]	5000	5020	5040	5060	5071
Out of consulting rooms[3]	5003	5023	5043	5063	5076
RACF[3]	5010	5028	5049	5067	5077
Telehealth					
Telehealth (video)	91790	91800	91801	91802	91920
Telephone	91890	91891	91900[4]	91910[4]	NA

[1]Residential Aged Care Facility

[2]Use on: public holiday; Sunday; before 8am or after 1 pm on Saturday; before 8am or after 8pm on any other day

[3]Use on: public holiday; Sunday; before 8am or after 12 noon on Saturday; before 8am or after 6pm on any other day

[4]Patients enrolled in MyMedicare only

AN.0.75 Initial Consultation for a new patient (item 296 in rooms, item 297 at hospital, item 299 for home visits or telehealth equivalent item 92437)

Referral for items 296, 297 and 299 or item 92437 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician.

It is intended that either item 296, 297, 299 or 92437 will be claimed once on the first occasion that the patient is seen by a consultant psychiatrist.

If the patient is referred by a medical practitioner in general practice or participating nurse practitioner for an assessment or management plan, item 291 or 92435 should be utilised (refer to note AN.0.30). It is not expected that 296, 297, 299 or 92437 items would be routinely used prior to item 291 or 92435.

Use of items 296, 297, 299 or 92435 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient. The use of items 296, 297, 299 or 92437 are identical except for the location of where the service is rendered. That is: item 296 is only available for consultations rendered in consulting rooms, item 297 is only available for consultations rendered at a hospital, and item 299 is only available for consultations rendered at a place other than consulting rooms or a hospital (such as in a patient's home) and item 92437 is available for telehealth consultations delivered by videoconference.

For patients who have already been seen by the consultant psychiatrist in the preceding 24 months the psychiatrist can use time-tiered attendance items 300, 302, 304, 306 and 308 or telehealth equivalent consultation items 91827 to 91831 and 91837 to 91839.

AN.0.76 Referral to Allied Mental Health Professionals (for new and continuing patients)

To increase the clinical treatment options available to psychiatrists and for which a Medicare benefit is payable, patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and intellectual disability are not regarded as mental disorders for the purposes of these items) a patient is eligible for up to 10 individual allied mental health services per calendar year by:

- clinical psychologists providing psychological therapies; or
- appropriately trained GPs or allied mental health professionals providing focused psychological strategy (FPS) services.

Referrals from psychiatrists to allied mental health professionals must be made under eligible MBS items. While such referrals are likely to occur for new patients seen under item 296, 297, 299 or 92437 or a referred psychiatrist assessment and management plan under item 291 or 92435, they are also available for patients at any point in treatment (under items 104 to 109, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 341, 342, 343, 344, 345, 346, 347, 349 or telehealth equivalent items, as clinically required, under the same arrangements and limitations as outlined above).

The ten individual services may consist of:

- psychological therapy services (items 80000 to 80015 or telehealth equivalent items 91166, 91167, 91181 or 91182) - provided by eligible clinical psychologists; and/or
- focused psychological strategies - allied mental health services (items 80100 to 80115 or telehealth equivalent items 91169, 91170, 91183 or 91184; 80125 to 80140 or telehealth equivalent items 91172, 91173, 91185 or 91186; 80150 to 80165 or telehealth equivalent items 91175, 91176, 91187 or 91188) - provided by eligible psychologists, occupational therapists and social workers.

Within the maximum service allocation of ten services, the allied mental health professional can provide one or more courses of treatment.

Group therapy services

In addition to the above services, patients will also be eligible to claim up to ten separate services within a calendar year for group therapy services (involving 6-10 patients) to which items:

- 80020 or 80021 (psychological therapy - clinical psychologist)
- 80120 or 80121 (focused psychological strategies - psychologist)
- 80145 or 80146 (focused psychological strategies - occupational therapist); and
- 80170 or 80171 (focused psychological strategies - social worker) apply.

These group services are separate from the individual services and do not count towards the ten individual services per calendar year maximum associated with those items.

Referral Requirements for Allied Health services

A referral for treatment must be in writing (signed and dated by the psychiatrist) and may include (unless clinically inappropriate):

- the patient's name, date of birth and address;
- the patient's symptoms or diagnostic assessment;
- the patient needs and goals of treatment (if clinically appropriate);
- a list of any current medications (if appropriate);
- the number of sessions before a psychiatry review is required; or the allied health practitioner should provide a written report back to the psychiatrist following the completed course of treatment, confirming the patient's need for a subsequent course of treatment if clinically needed.

Maximum session limit for each course of treatment apply:

Initial course of treatment – a maximum of six sessions. Subsequent course of treatment – a maximum of six sessions up to the patient's cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

AN.0.77 Group therapy by psychiatrist (Item 346)

This item refers to family group therapy supervised by consultant psychiatrists. A formal intervention is undertaken with a specific therapeutic outcome, such as security of attachment, improved family interaction and/or communication. A child less than twelve months can count as a patient for the purposes of this item if the child has been separately referred for this service and the above criteria are met.

AN.1.1 Patients Usual Medical Practitioner for Telehealth and phone

It is a legislative requirement that GPs and prescribed medical practitioners working in general practice must only perform a telehealth or telephone service where they have an established clinical relationship with the patient.

An established clinical relationship is defined as:

· the medical practitioner who performs the service has provided a face-to-face service to the patient in the last 12 months; or

· the medical practitioner who performs the service is located at a medical practice, and the patient has a face-to-face service arranged by that practice in the last 12 months. This can be a service performed by another doctor located at the practice, or a service performed by another health professional located at the practice (such as a practice nurse or Aboriginal and Torres Strait Islander health worker); or

· the medical practitioner who performs the service is a participant in the Approved Medical Deputising Service (AMDS) program, and the Approved Medical Deputising Service provider (AMDS provider) that employs the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the last 12 months.

This requirement does not apply to a person who is under the age of 12 months, a person who is experiencing homelessness, a person receiving treatment through Mental Health telehealth items, a person receiving treatment through Blood Borne Virus, Sexual or Reproductive health telehealth items, a person living in a natural disaster affected area, a person receiving an urgent after-hours service (in unsociable hours), or a person who receives the service from a medical practitioner located at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service.

person who is experiencing homelessness means when a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

(a) is in a dwelling that is inadequate; or

(b) has no tenure, or if their initial tenure is short and not extendable; or

(c) does not allow them to have control of, and access to space for social relations.

person receiving treatment through Mental Health telehealth items means services must be claimed as specific GP or prescribed medical practitioner mental health and eating disorder telehealth items.

person receiving treatment through Blood Borne Virus, Sexual or Reproductive Health telehealth items means services must be claimed as specific GP or prescribed medical practitioner telehealth items (see also AN.40.5)

people living in a natural disaster affected area is defined as a State or Territory local government area which is currently declared as a natural disaster area by a State or Territory Government until that declaration is deemed to have expired.

AN.2.1 Limitation of items - certain attendances by diagnostic imaging providers

Consultations rendered by specialist radiologists

Medicare benefits are not payable for items 52, 53, 54, 57, 151, 104 and 105 when claimed by a specialist radiologist in association with any of the following diagnostic imaging items:

(a) an item in Subgroup 6 of Group I1;
(b) an item in any of Subgroups 1 to 7 of Group I3;
(c) items 58900 and 58903 in Subgroup 8 of Group I3; and
(d) item 59103 in Subgroup 9 of Group I3.

Consultations rendered in association with magnetic resonance imaging (MRI) services - Group I5

Medicare benefits are not payable for items 52, 53, 54, 57, 151, 104 and 105 in association with MRI services unless the providing practitioner determines that the consultation is necessary for the treatment or management of the patient's condition.

The restrictions above apply when these services are performed by the same practitioner, on the same patient, on the same day.

AN.3.1 Subsequent attendance items

The current regulations prohibit the payment of Medicare benefits for subsequent attendance items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618 if a claim is made for any Group T8 item (30001-50952) with a schedule fee of equal to or greater than $341.75 on the same day. Non-compliance with the regulations can result in a referral to an appropriate regulatory body – such as the Professional Services Review. Subsequent attendance items (111, 117, and 120) can

only be claimed on the same day as Group T8 items with schedule fees of equal to or greater than $341.75, if the procedure is urgent and not able to be predicted prior to the commencement of the attendance. It is therefore expected that these items would be claimed only in exceptional circumstances.

Subsequent attendance item 115 can only be claimed, if the nature of the attendance was not able to be predicted prior to the procedure.

Item 115 should not be claimed if the consultation relates to the booked Group T8 procedure. Any consultation component related to the booked Group T8 procedure is considered to be covered under the fee for that procedure, if the Schedule fee is $341.75 or more.

Should a component of the consultation be unrelated to the booked T8 procedure and it is considered by the medical practitioner that it would be a clinical risk to defer this consultation then item 115 could be claimable.

It would not be appropriate to claim item 115 if a patient attends for the booked operation, and prior to surgery an examination is conducted relevant to performing that procedure; together with a discussion of the outcomes and aftercare. If the consultation extends beyond this; including the development of a management plan involving a broader diagnosis, prognosis, associated treatments and follow-up; then it could be appropriate to claim item 115.

In claiming item 115, the specialist or consultant physician must be satisfied that it would be a clinical risk to defer the consultation for the patient at this time.

Where item 115 is claimed, the records for the consultation should clearly identify why the consultation is considered necessary for the patient including the clinical risk to defer the consultation.

AN.7.1 Prescribed Medical Practitioners

A prescribed medical practitioner is a medical practitioner:

(a) who is not a general practitioner (see GN.4.13), specialist or consultant physician, and

(b) who:

a. is registered under section 3GA of the Act and is practising during the period, and in the location in respect of which the medical practitioner is registered, and insofar as the circumstances specified for paragraph 19AA(3)(b) of the Act apply; or

b. is covered by an exemption under subsection 19AB(3) of the Act; or

c. first became a medical practitioner before 1 November 1996.

AN.7.2 GENERAL ATTENDANCE ITEMS – MEDICAL PRACITIONERS AND PRESCRIBED MEDICAL PRACITIONERS

GENERAL ATTENDANCE ITEMS – MEDICAL PRACITIONERS[1] (MPs) AND PRESCRIBED MEDICAL PRACITIONERS[2] (PMPs)

	Level A **Straightforward**	**Level B** **5-25 minutes**	**Level C** **25+ minutes**	**Level D** **45+ minutes**	**Level E** **60+ minutes**
Business hours					

In consulting rooms (MP)[1]	52	53	54	57	151
In consulting rooms (PMP)[2] MM2-7[3]	179	185	189	203	301
Out of consulting rooms (MP)	58	59	60	65	165
Out of consulting rooms (PMP) MM2-7	181	187	191	206	303
RACF (MP)	90092	90093	90095	90096	90098
RACF (PMP) MM2-7	90183	90188	90202	90212	90215
After-hours					
In consulting rooms (MP)	5200	5203	5207	5208	5209
In consulting rooms (PMP)	733	737	741	745	2197
Out of consulting rooms (MP)	5220	5223	5227	5228	5261
Out of consulting rooms (PMP)	761	763	766	769	2198
RACF (MP)	5260	5263	5265	5267	5262
RACF (PMP)	772	776	788	789	2200
Telehealth					
Telehealth (video) (MP)	91792	91803	91804	91805	91923
Telehealth (video) (PMP) MM 2-7	91794	91806	91807	91808	91926
Telephone (MP)	91892	91893	91903[4]	91913[4]	NA
Telephone (PMP) MM2-7			91906[4]	91916[4]	

[1]MP items can be claimed by all MPs who are not general practitioners.

[2]PMP items can be claimed by medical practitioners that are not general practitioners, specialists or consultant physicians.

[3]MM means “Modified Monash”. The Modified Monash Model is how the department defines whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

[4]Available to patients enrolled in MyMedicare only.

AN.7.3 Prescribed Medical Practitioner Prolonged Attendance in Treatment of a Critical Condition (Items 214 to 220)

The conditions to be met before services covered by items 214-220 attract benefits are:-

(i) the patient must be in imminent danger of death;

(ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and

(iii) if personal attendance on a single patient is provided by 1 or more prescribed medical practitioners (see note AN.7.1) concurrently, each practitioner may claim an attendance fee.

Note: Medicare benefits are not payable for the issue of a death certificate, although an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.7.4 Prescribed Medical Practitioner Family Group Therapy (Items 221, 222 and 223)

These items refer to family group therapy supervised by prescribed medical practitioners (see note AN.7.1). To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

Telephone consultations, letters of advice by prescribed medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 221, 222, 223, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.7.13 Prescribed Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander People (Item 228)

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

- An Aboriginal or Torres Strait Islander child who is less than 15 years.
- An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.
- An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

A health assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

MBS item 228 must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient; and

(e) keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the prescribed medical practitioner [see note AN.7.1] considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the prescribed medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from https://www.health.gov.au/resources/apps-and-tools/the-australian-type-2-diabetes-risk-assessment-tool-ausdrisk.

A health assessment may only be claimed by a prescribed medical practitioner.

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, "usual doctor" means the prescribed medical practitioner, or a medical practitioner working in the same medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

The health assessment for Aboriginal and Torres Strait Islander People is not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

A health assessment should not take the form of a health screening service (see General Explanatory Note GN.13.33).

MBS health assessment item 228 must be provided by a prescribed medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist prescribed medical practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the prescribed medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the prescribed medical practitioner.

The prescribed medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Prescribed medical practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Item 228 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 228 can be claimed for services provided by prescribed medical practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of items 10990 and 10991 are satisfied.

An eligible patient may only receive the Health Assessment for Aboriginal and Torres Strait Islander People using either item 228 or item 715 once in a 9-month period.

AN.7.14 Prescribed Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Child less than 15 years of age (Item 228)

An Aboriginal and Torres Strait Islander child health assessment must include:

a. a personal attendance by a prescribed medical practitioner (see note AN.7.1);

b. taking the patient's medical history, including the following:

i. mother's pregnancy history;

ii. birth and neo-natal history:

iii. breastfeeding history;

iv. weaning, food access and dietary history;

v. physical activity;

vi. previous presentations, hospital admissions and medication usage;

vii. relevant family medical history;

viii. immunisation status;

ix. vision and hearing (including neonatal hearing screening);

x. development (including achievement of age appropriate milestones);

xi. family relationships, social circumstances and whether the person is cared for by another person;

xii. exposure to environmental factors (including tobacco smoke);

xiii. environmental and living conditions;

xiv. educational progress;

xv. stressful life events;

xvi. mood (including incidence of depression and risk of self-harm);

xvii. substance use;

xviii. sexual and reproductive health; and

xix. dental hygiene (including access to dental services).

c. examination of the patient, including the following:

i. measurement of height and weight to calculate body mass index and position on the growth curve;

ii. newborn baby check (if not previously completed);

iii. vision (including red reflex in a newborn);

iv. ear examination (including otoscopy);

v. oral examination (including gums and dentition);

vi. trachoma check, if indicated;

vii. skin examination, if indicated;

viii. respiratory examination, if indicated;

ix. cardiac auscultation, if indicated;

x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;

xi. assessment of parent and child interaction, if indicated; and

xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:

i. haemoglobin testing for those at a high risk of anaemia; and

ii. audiometry, if required, especially for those of school age

e. assessing the patient using the information gained in the child health check; and

f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

AN.7.15 Prescribed Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Adult Aged 15 Years to 54 Years (Item 228)

An Aboriginal and Torres Strait Islander adult health assessment must include:

a. a personal attendance by a prescribed medical practitioner (see note AN.7.1);

b. taking the patient's medical history, including the following:

i. current health problems and risk factors;

ii. relevant family medical history;

iii. medication usage (including medication obtained without prescription or from other doctors);

iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;

v. sexual and reproductive health;

vi. physical activity, nutrition and alcohol, tobacco or other substance use;

vii. hearing loss;

viii. mood(including incidence of depression and risk of self-harm);

ix. family relationships and whether the patient is a carer, or is cared for by another person; and

x. vision

c. examination of the patient, including the following:

i. measurement of the patient's blood pressure, pulse rate and rhythm;

ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;

iii. oral examination (including gums and dentition);

iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and

v. urinalysis (by dipstick) for proteinurea;

vi. eye examination;

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):

i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;

ii. cervical screening;

iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and

iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).

e. assessing the patient using the information gained in the adult health assessment; and

f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment.

AN.7.16 Prescribed Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Older Person Aged 55 Years and Over (Item 228)

An Aboriginal and Torres Strait Islander Older Person's health assessment must include:

a. a personal attendance by the prescribed medical practitioner (see note AN.7.1);

b. measurement of the patient's blood pressure, pulse rate and rhythm;

c. an assessment of the patient's medication;

d. an assessment of the patient's continence;

e. an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;

f. an assessment of the patient's physical function, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3months;

g. an assessment of the patient's psychological function, including the patient's cognition and mood;

h. an assessment of the patient's social function, including:

i. the availability and adequacy of paid, and unpaid, help;

ii. whether the patient is responsible for caring for another person;

i. an eye examination

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with

c. recommendations on matters covered by the health assessment; and

d. offering the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

AN.7.17 Prescribed Medical Practitioner Chronic Disease Management (Items 229 to 233)

Description	Item No	Minimum claiming period*
Preparation of a GP Management Plan (GPMP)	229	12 months
Coordination of Team Care Arrangements (TCAs)	230	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	231	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	232	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	233	3 months

* CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Patients with a mental health condition being treated under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS)* (Better Access) initiative or under an Eating Disorder Treatment and Management Plan (EDTMP) are also eligible to receive a TCA service. However, the prescribed medical practitioner (see note AN.7.1) should consider whether it would be more appropriate to review any existing TCA rather than develop a new one specifically for the patient's mental health condition.

Regulatory requirements

Items 229, 230, 231, 232 and 233 provide rebates for prescribed medical practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Items 723 and 732 also provide rebates to manage mental health conditions by coordinating the development or review of TCAs. They apply for a patient who is being treated under the Better Access initiative or has an EDTMP.

Treated under the Better Access initiative means a patient has been referred for a:

- a focussed psychological strategies service delivered by a GP, OMP, psychologist, social worker or occupational therapist, or
- psychological therapy service delivered by a clinical psychologist

Please note: TCAs do not constitute a referral. A referral is still required to access allied mental health services.

Restrictions on claiming multiple Chronic Disease Management Items

Patients may receive chronic disease management services using MBS items 229 to 223 and 721 to 732. However, once a patient has received a service using an MBS item from **either** group of MBS chronic disease management items, the patient may not receive another MBS chronic disease management service until the minimum claiming period has expired. The only exception is where there are exceptional circumstances necessitating an earlier performance of the service (see **Claiming of benefits** below).

If a prescribed medical practitioner is not sure if a patient is eligible for an MBS chronic disease management service, they may telephone Services Australia on 132011, with the patient present, to check eligibility.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of MBS general consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 123, 124, 151, 165, 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 585, 588, 591, 594, 599, 600, 733, 737, 741, 745, 761, 763, 766, 769, 2197, 2198, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5071, 5076, 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228, 5261, 91790, 91792, 91794, 91800, 91801, 91802, 91803, 91804, 91805, 91806, 91807, 91808, 91890, 91891, 91892, 91893, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923, 91926, 92210, 92211 with chronic disease management items 229, 230 and 233 is not permitted for the same patient, on the same day.

Patient eligibility

CDM items 229, 230 and 233 are available to:

i patients in the community; and

ii private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

CDM items 229, 230 and 233 are not available to:

i public in-patients of a hospital; or

ii care recipients in a residential aged care facility.

CDM item 231 is available to:

i patients in the community;

ii both private and public in-patients being discharged from hospital.

CDM item 231 is not available to:

i care recipients in a residential aged care facility.

CDM item 232 is available to care recipients in a residential aged care facility only.

Components of service

Item 229

A comprehensive written plan must be prepared describing:

a. the patient's health care needs, health problems and relevant conditions;

b. management goals with which the patient agrees;

c. actions to be taken by the patient;

d. treatment and services the patient is likely to need;

e. arrangements for providing this treatment and these services; and

f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the prescribed medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

b. record the plan; and

c. record the patient's agreement to the preparation of the plan; and

d. offer a copy of the plan to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees); and

e. add a copy of the plan to the patient's medical records.

Item 230

When coordinating the development of Team Care Arrangements (TCAs), the prescribed medical practitioner must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another prescribed medical practitioner, when making arrangements for the multidisciplinary care of the patient; and

b. prepare a document that describes:

i treatment and service goals for the patient;

ii treatment and services that collaborating providers will provide to the patient; and

iii actions to be taken by the patient;

iv arrangements to review (i), (ii) and (iii) by a date specified in the document; and

c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees);

d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and

e. record the patient's agreement to the development of TCAs;

f. give copies of the relevant parts of the document to the collaborating providers;

g. offer a copy of the document to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees); and

h. add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the prescribed medical practitioner can be another prescribed medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 231

A multidisciplinary care plan means a written plan that:

a. is prepared for a patient by:

i a prescribed medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another prescribed medical practitioner; or

ii a collaborating provider (other than a prescribed medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the prescribed medical practitioner must:

i. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

j. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a prescribed medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the prescribed medical practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232 can also be used for contribution to 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 235 to 240 apply).

Item 233

An "associated medical practitioner" is a medical practitioner who, if not engaged in the same general practice as the prescribed medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the prescribed medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees) the steps involved in the review;

b. record the patient's agreement to the review of the plan;

c. review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees);

f. add a copy of the amended document to the patient's records; and

g. provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the prescribed medical practitioner must:

a. explain the steps involved in the review to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees);

b. record the patient's agreement to the review of the TCAs or plan;

c. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the prescribed medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees);

f. provide for further review of the amended plan by a date specified in the plan;

g. give copies of the relevant parts of the amended plan to the collaborating providers; and

h. add a copy of the amended document to the patient's records.

Item 233 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan or to COORDINATE REVIEW OF A Discharge Care, where these services were coordinated or prepared by that prescribed medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 235 to 240 apply.

Claiming of benefits

Each service to which item 233 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 233 can be claimed twice on the same day - for example for reviewing a GP Management Plan and another for reviewing Team Care Arrangements (TCAs) provided both are delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 233 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 233 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

Non electronic Medicare claiming of items 233 on the same date

The time that each item 233 commenced should be indicated next to each item

Electronic Medicare claiming of item 233 on the same date

Medicare Easyclaim: use the 'ItemOverrideCde" set to 'AP', which flags the item as not duplicate services
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as not duplicate

Items 229, 230 233

The GP Management Plan items (229 and 233) and the Team Care Arrangement items (230 and 233) cannot be claimed by prescribed medical practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Items 229-233 should generally be undertaken by the patient's usual medical practitioner. This means the prescribed medical practitioner, or a medical practitioner working in the same medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of medical services to the patient over the next twelve months. The term "usual medical practitioner" would not generally apply to a practice that provides only one specific CDM service.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist with items 229, 230 and 233 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the medical practitioner must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125).

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

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

AN.7.18 Prescribed Medical Practitioner Medication Management Reviews (Items 245 and 249)

Item 245 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 245), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen and prevent medication-related problems through a team approach, involving the patient's prescribed medical practitioner (see note AN.7.1) and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review:

- patients for whom quality use of medicines may be an issue or;

- patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR's are targeted at patients who are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- have had significant changes made to medication treatment regimen in the last three months;
- taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- experiencing symptoms suggestive of an adverse drug reaction;
- displaying sub-optimal response to treatment with medicines;
- suspected of non-compliance or inability to manage medication related therapeutic devices;
- having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- attending a number of different doctors, both prescribed medical practitioners and specialists; and/or
- recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, prescribed medical practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

- Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;
- Is subject to a chronic condition and/or complex medication regimen; and
- Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the prescribed medical practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a prescribed medical practitioner must, with the patient's consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12-month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

A DMMR includes all DMMR-related services provided by the prescribed medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 245 are payable only once in each 12-month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such

cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 245 may be claimed.

If the prescribed medical practitioner determines that a DMMR is not necessary, item 245 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the prescribed medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual medical practitioner. This is the prescribed medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the prescribed medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the prescribed medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

A DMMR referral form is available for this purpose. If this form is not used, the prescribed medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

- Receiving a written report from the reviewing pharmacist; and
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and
- Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of a written medication management plan following discussion with the patient includes:

- Developing a draft medication management plan and discussing this with the patient; and

- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

Item 249 - Residential Medication Management Review

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility

RMMRs are available to:

- new residents on admission into a RACF; and
- existing residents on an 'as required' basis, where in the opinion of the resident's prescribed medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a prescribed medical practitioner must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A prescribed medical practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and prescribed medical practitioner agree that issues arising out of the review should be considered in a case conference.

A RMMR comprises all activities to be undertaken by the prescribed medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12-month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

- any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
- any subsequent follow up should be treated as a separate consultation item;
- an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the prescribed medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the prescribed medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual medical practitioner'. This is the prescribed medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

Prescribed medical practitioners who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable timeframe. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's prescribed medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The prescribed medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The prescribed medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

AN.7.22 Prescribed Medical Practitioner Mental Health Treatment

This note provides information on the Mental Health Treatment items 272, 276, 277, 279, 281 and 282, and is also applicable for video and phone equivalent MBS items 92118, 92119, 92120, 92121, 92122, 92123, 92132 and 92133. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

The Mental Health Treatment items define services for which Medicare rebates are payable where prescribed medical practitioners (see note AN.7.1) undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296, 297, 299 and 92437), clinical psychologists (items 80000, 80005, 80010, 80015, 91166, 91167, 91181 and 91182) and allied mental health providers (items 80100, 80105, 80110, 80115, 80125, 80130, 80135, 80140, 80150, 80155, 80160, 80165, 91169, 91170, 91172, 91173, 91175, 91176, 91183, 91184, 91185, 91186, 91187 and 91188).

The Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services; and
- review and ongoing management as required.

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by prescribed medical practitioners.

Training Requirements (items 281, 282, 92122 and 92123)

Prescribed medical practitioners providing GP Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 281, 282, 92122 and 92123. For prescribed medical practitioners who have not undertaken training, items 272, 276, 92118 and 92119 are available. Items 272, 281, 92118 and 92122 provides for a GP Mental Health Treatment Plan lasting at least 20 minutes and items 276, 282, 92119 and 92123 provides for a GP Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that prescribed medical practitioners providing mental health treatment have appropriate mental health training. Medical professional organisations support the value of appropriate mental health training for prescribed medical practitioners using these items.

Which patients are eligible - Mental Disorder

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the Mental Health Treatment items.

These services are available to eligible patients in the community. Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the service is provided as part of an episode of hospital treatment it must be claimed at the 75% MBS rebate - see note GN.1.2. Prescribed medical practitioners are able to contribute to care plans for patients using item 231, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 232.

PREPARING A GP MENTAL HEALTH TREATMENT PLAN (Item 272, 276, 281, 282, 92118, 92119, 92122 or 92123)

What is involved - Assess and Plan

A rebate can be claimed once the prescribed medical practitioner has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

Assessment

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Treatment Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 272, 276, 281, 282, 92118, 92119, 92122 or 92123.

In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner.

Prescribed medical practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Preparation of a GP Mental Health Treatment Plan

In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained medical practitioner or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through items 272, 276, 281, 282, 92118, 92119, 92122 or 92123 or through GP items 2700, 2701, 2715, 2717 92112, 92113, 92116 or 92117, a patient is eligible to be referred for up to 10 Medicare rebateable mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies). Please note group therapy does not include family and couples therapy.

When referring patients prescribed medical practitioners should provide the information outlined under the ‘Referral’ heading below. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the prescribed medical practitioner.

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 277, 92120 or 92132, or GP item 2712, 92114 or 92126).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN (Item 277, 92120 or 92132)

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

A rebate can be claimed once the prescribed medical practitioner who prepared the patient's GP Mental Health Treatment Plan (or another medical practitioner in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Treatment Plan by completing the activities that must be included in a review and meeting the relevant requirements listed under 'Additional Claiming Information'. The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291 or 92435), as if that patient had a GP Mental Health Treatment Plan.

The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- modification of the documented GP Mental Health Treatment Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the prescribed medical practitioner as part of ongoing management.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12-month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item.

GP MENTAL HEALTH TREATMENT CONSULTATION (Item 279, 92121 or 92133)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services. This does not include referral for Medicare rebateable services for focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the prescribed medical practitioner under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291 or 92435).

Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a prescribed medical practitioner is managing a patient under a referred psychiatrist assessment and management plan, a patient is eligible for up to 10 Medicare rebateable allied mental health services per calendar year for services by:

- clinical psychologists providing psychological therapies; or
- appropriately trained medical practitioners or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy, in line with their clinical need. Please note group therapy does not include family and couples therapy.

When preparing a patient's Mental Health Treatment Plan and making a referral prescribed medical practitioners should speak to the patient about their treatment needs and the type of treatment, for example individual and/or group sessions, that might be suitable for their particular circumstances.

Please note if a referral does not specify whether it relates to individual or group therapy, the patient can use a referral to access either or both individual and group therapy treatment options.

A referral for mental health services should be in writing (signed and dated by the prescribed medical practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis, including whether a GP Mental Health Treatment Plan has been completed for the patient;
- a list of any current medications;
- the number of sessions the patient is being referred for (the 'course of treatment');
- a statement about whether the patient has a mental health treatment plan or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered.

Where appropriate, and with the patient's agreement, the prescribed medical practitioner can also attach a copy of the mental health treatment plan to the referral.

Including these details on a referral will assist with any auditing undertaken by the Department of Health and Aged Care.

Number of Sessions

The prescribed medical practitioner can decide how many sessions the patient will receive in a course of treatment, within the maximum session limit for the course of treatment. The maximum session limit for each course of treatment is set out below:

- Initial course of treatment – a maximum of six sessions.
- Subsequent course of treatment – a maximum of six sessions up to the patient's cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

The prescribed medical practitioner should consider the patient's clinical need for further sessions after each course of treatment, including through considering the written report provided by the treating practitioner. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the maximum number of services available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary

Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Specifying the Number of Sessions in a Referral

If the prescribed medical practitioner:

- Does not specify the number of sessions
- Specifies a number of sessions above the maximum allowed for the course of treatment
- Specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year)

Then the treating practitioner can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of sessions allowed for that particular course of treatment (as set out above), and
- the maximum number of sessions allowed in a calendar year.

The treating practitioner must still provide a report at the end of a course of treatment in line with standard practice for these services. The referring prescribed medical practitioner should therefore consider the treating practitioner's report on the services provided to the patient, and the need for further treatment.

Verbal Referral

A prescribed medical practitioner can verbally refer a patient for Better Access services only if:

- in their clinical judgement they consider it is necessary for the patient to have immediate access to support from an allied mental health professional, and
- it is not practicable in the circumstances to provide a written referral – for example, to do so would cause delays in treatment to the patient's detriment, and
- the allied mental health professional documents in writing that they are treating the patient based on the prescribed medical practitioner's verbal referral, and
- the prescribed medical practitioner provides a written referral to the allied mental health professional as soon as possible afterwards.

While waiting for the referring practitioner to provide a written referral, the treating practitioner can provide treatment according to the verbal referral until the referred number of sessions have been completed. If there is any doubt about the number of sessions the patient was verbally referred for, the treating practitioner should follow the guidance provided above under the heading 'Specifying the number of sessions in a referral'.

A verbal referral does not replace the requirement for the prescribed medical practitioner to review the patient's progress (taking into account the written report from their treating allied health professional) after each course of treatment.

Referrals for the Additional 10 Sessions (available until 31 December 2022)

In response to the COVID-19 pandemic, the number of Medicare rebateable individual mental health services was temporarily increased from 10 to 20 per calendar year until 31 December 2022.

A patient does not need a new referral to access Better Access sessions from 1 January 2023. If the patient has a current referral (either for the initial 10 sessions or the additional 10 sessions) and has not used all of the sessions, they can use that referral to access sessions in 2023. However, they cannot receive more than 10 individual sessions in 2023.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the prescribed medical practitioner must ensure that:

- the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and
- the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a benefit for that service, the prescribed medical practitioner must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The prescribed medical practitioner may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and
- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where an additional consultation is undertaken, both services must be clinically relevant and all item requirements must be met. For example, for item 272, the duration of the service must have been at least 20 minutes. The time of the preceding consultation must not be counted towards the time of the mental health service.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the prescribed medical practitioner. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to prescribed medical practitioners in provision of mental health care.

Links to other Medicare Services

It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 229, 230, 231, 232 and 233, and GP items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the GP Mental Health Treatment items.

- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.
- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the prescribed medical practitioner is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

AN.7.23 Prescribed Medical Practitioner Provision of Focussed Psychological Strategies (Items 283, 285, 286, 287, 91820, 91821, 91844 and 91845)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan.

Minimum Requirements

All consultations providing Focussed Psychological Strategies must be rendered by a prescribed medical practitioner (see note AN.7.1).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to prescribed medical practitioners who are registered with the Services Australia as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 283, 285, 286, 287, 91820, 91821, 91844 and 91845 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 mental health services under these item numbers per calendar year. The 10 services may consist of: prescribed medical practitioner focussed psychological strategies services (items 283, 285, 286, 287, 91820, 91821, 91844 and 91845) or GP items (2721, 2723, 2725, 2727, 91818, 91819, 91842 and 91843); and/or psychological therapy services (items 80000, 80005, 80010, 80015, 91166, 91167, 91181 and 91182); and/or focussed psychological strategies – allied mental health services (items 80100, 80105, 80110, 80115, 80125, 80130, 80135, 80140, 80150, 80155, 80160, 80165, 91169, 91170, 91172, 91173, 91175, 91176, 91183, 91184, 91185, 91186, 91187 and 91188).

Out-of-Surgery Consultation

It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A range of acceptable strategies has been approved for use by prescribed medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy

3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing

4. Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal therapy

6. Eye-Movement Desensitisation Reprocessing (EMDR)

Mental Disorder

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

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

AN.7.24 Prescribed Medical Practitioner After-Hours Attendances To Which No Other Item Applies (Items 733 to 789 and 2917 to 2200)

After-hours attendance items may be claimed as follows:

Items **733, 737, 741, 745 and 2197** apply only to a professional attendance on 1 patient on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1 pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items **761, 763, 766, 769, 772, 776, 788, 789, 2198 and 2200** apply to a professional attendance on 1 or more patients on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

AN.7.25 Prescribed Medical Practitioner Non-Directive Pregnancy Support Counselling Service (Item 792)

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy, by an eligible prescribed medical practitioner (see note AN.7.1) or allied health professional on referral from a prescribed medical practitioner.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

- Item 792 – services provided by an eligible prescribed medical practitioner;
- Item 4001 - services provided by an eligible GP;
- Item 81000 - services provided by an eligible psychologist;
- Item 81005 - services provided by an eligible social worker; and
- Item 81010 - services provided by an eligible mental health nurse.

This note relates to the provision of a non-directive pregnancy support counselling service by an eligible prescribed medical practitioner.

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the prescribed medical practitioner undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 792 are available to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or item 4001, 81000, 81005 or 81010 applies in relation to that pregnancy.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items – 792, 4001, 81000, 81005 and 81010.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Services Australia on 132 011. Alternatively, the prescribed medical practitioner may check with Services Australia (although the patient must be present to give permission).

Item 10990 or item 10991 can also be claimed in conjunction with item 792 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

Minimum Requirements

This service may only be provided by a prescribed medical practitioner who has completed appropriate non-directive pregnancy counselling training.

AN.7.27 Prescribed Medical Practitioner Multidisciplinary Case Conferences (Items 235 to 244)

Items 235 to 244 provide rebates for prescribed medical practitioners (see note AN.7.1) to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into

the community from hospital or people living in residential aged care facilities. This group of items include two items for prescribed medical practitioners participating in cancer care case conferences.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 235, 236 and 237, the prescribed medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

(b) record the patient's agreement to the conference; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the prescribed medical practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items 238, 239 and 240, the prescribed medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the prescribed medical practitioner's participation in the conference; and

(b) record the patient's agreement to the prescribed medical practitioner's participation; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

Cancer care case conference items 243 and 244

For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;

- the billing prescribed medical practitioner must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item;

- only one prescribed medical practitioner is eligible to claim item 243 for each patient case conference. This should be the prescribed medical practitioner who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating prescribed medical practitioner;

- each billing prescribed medical practitioner must ensure that their patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;
- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;
- suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietitian; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or speech pathologist;
- in general, it is expected that no more than two case conferences per patient per year will be billed by a prescribed medical practitioner; and
- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes (eg. community or discharge case conferences).

ADDITIONAL INFORMATION

Usual medical practitioner

Items 235 to 244 should generally be undertaken by the patient's usual medical practitioner. This is a prescribed medical practitioner, or a medical practitioner working in the same medical practice that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

Organisation and coordination of a multidisciplinary discharge case conference (items 235, 236 and 237) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information

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

AN.7.31 Provision of Focussed Psychological Strategies Services by Eligible Prescribed Medical Practitioners to a Person Other than the Patient (309, 311, 313, 315, 91862, 91863, 91866 and 91867)

OVERVIEW

The purpose of these MBS items is to enable eligible prescribed medical practitioners (see note AN.7.1) to involve another person in a patient's treatment, under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, where:

- the eligible prescribed medical practitioner providing the service determines it is clinically appropriate,
- the patient consents for the service to be provided to the other person as part of their treatment,
- the service is part of the patient's treatment, and
- the patient is not in attendance.

These MBS items recognise the important role another person, such as a family member or carer, can play in supporting patients with mental illness, and the benefits that can result from involving them in treatment.

Under these MBS items, Medicare rebates are available to a patient for up to two services provided to another person per calendar year. Any services delivered using these items count towards the patient's course of treatment and calendar year allocations under Better Access. For further information on patient allocations, please see explanatory note AN.7.22.

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

SERVICES ATTRACTING MEDICARE REBATES

MBS items

There are eight MBS items for the provision of focussed psychological strategies (FPS) health services to a person other than the patient by eligible prescribed medical practitioners:

- 309, 311, 313 and 315 for provision of in person FPS services by a prescribed medical practitioner;
- 91862 and 91863 for provision of telehealth FPS services by a prescribed medical practitioner; and
- 91866 and 91867 for provision of phone FPS services by a prescribed medical practitioner.

Telehealth services are the preferred approach for substituting a face-to-face consultation. However, eligible prescribed medical practitioners will also be able to offer phone (audio-only) services if video is not available or appropriate. As outlined above, there are separate items available for phone services.

To claim these MBS items the eligible prescribed medical practitioner must meet the provider eligibility requirements for the delivery of FPS services. For further information, please see explanatory note AN.7.23.

Eligible focussed psychological strategies services

A range of acceptable strategies have been approved for use by eligible prescribed medical practitioners utilising FPS items. For further information, please see explanatory note AN.7.23.

Eligible prescribed medical practitioners must use their professional judgement to determine what would be an appropriate FPS service to deliver to another person as part of the patient's treatment within the approved list of FPS.

Publicly funded services

These MBS items do not apply for services provided by any other Commonwealth or state funded services, or provided to an admitted patient of a hospital, unless there is an exemption under subsection 19(2) of the *Health Insurance Act 1973*.

SERVICE LIMITATIONS

Medicare rebates are available to a patient for up to two services provided to another person per calendar year. The two services may consist of:

- Prescribed medical practitioner items: 309, 311, 313, 315, 91862, 91863, 91866 and 91867
- GP items: 2739, 2741, 2743, 2745, 91859, 91861, 91864 and 91865
- Clinical psychologist items: 80002, 80006, 80012, 80016, 91168, 91171, 91198 and 91199
- Psychologist items: 80102, 80106, 80112, 80116, 91174, 91177, 91200 and 91201
- Occupational therapist items: 80129, 80131, 80137, 80141, 91194, 91195, 91202 and 91203
- Social worker items: 80154, 80156, 80162, 80166, 91196, 91197, 91204 and 91205

Any services delivered using these MBS items count towards:

- the maximum session limit for each course of treatment under Better Access, and
- the patient's calendar year allocation for individual services under Better Access.

For further information on the maximum session limits for each course of treatment and maximum calendar year allocation, please see explanatory note AN.7.22.

CLAIMING REQUIREMENTS

Determining service is clinically appropriate

The eligible prescribed medical practitioner providing the service must use their professional judgment to determine it is clinically appropriate, and would form part of the patient's treatment, to provide a FPS service to another person.

This determination must be recorded in writing in the patient's records.

Obtaining and recording patient consent to deliver the service

The patient must consent to the other person receiving an FPS service using these MBS items. The eligible prescribed medical practitioner providing the service must:

- Explain the service to the patient.
- Obtain the patient's consent for the service to be provided to the other person as part of the patient's treatment.
- Make a written record of the patient's consent.

The patient may withdraw their consent at any time.

In the case of a child, the general laws relating to consent to medical treatment apply. These may differ between states and territories, and the prescribed medical practitioner should be aware of the requirements in the relevant state or territory.

Service must be part of the patient's treatment

Any service delivered using these MBS items must be part of the patient's treatment. These MBS items are not for the purposes of providing mental health treatment to the person receiving the service. Should that person also require mental health treatment the patient MBS items should be claimed (where all the requirements for the relevant item descriptor have been met).

Patient is not in attendance

These MBS items are for eligible prescribed medical practitioners to provide services to another person when the patient is not in attendance. If the patient is in attendance, the prescribed medical practitioner can consider whether the requirements of the patient MBS items for delivering Better Access services have been met. For further information, please see explanatory note AN.7.23.

Course of treatment

These services may be accessed at any stage of a patient's course of treatment and do not need to be accessed consecutively, provided no more than two services are delivered to another person and delivering these services does not exceed the maximum allowed for the patient in a course of treatment or calendar year under Better Access.

ADDITIONAL INFORMATION

Out-of-pocket expenses and Medicare safety net

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Checking the number of services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm the number of mental health services already claimed by the patient during the calendar year. Eligible prescribed medical practitioners can call Services Australia on 132 150 to check this information, while patients can call on 132 011.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia Medicare Provider Enquiry Line on 132 150.

AN.7.32 Mental Health Case Conferences - Prescribed Medical Practitioners

Items 969, 971, 972, 973, 975, 986 provide rebates for a prescribed medical practitioner (see note AN.7.1), to organise and coordinate, or participate in, mental health case conferences. They apply for a patient who is being treated under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative (Better Access) or an eating disorder treatment and management plan (EDTMP).

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient. A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

PATIENT ELIGIBILITY

Case conferences using these new MBS items can be held for patients who have been referred for treatment under Better Access or have an active eating disorder treatment and management plan.

Patients can be referred for treatment under Better Access by a:

- GP or prescribed medical practitioner under a mental health treatment plan or psychiatrist assessment and management plan,

- psychiatrist, or
- paediatrician.

Treated under Better Access means a patient has been referred for a:

- a focussed psychological strategies service delivered by a GP, prescribed medical practitioner, psychologist, social worker or occupational therapist, or
- psychological therapy service delivered by a clinical psychologist

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 969, 971 and 972, the provider must:

a. explain to the patient the nature of a mental health case conference and ask for their agreement to the conference taking place; and
b. record the patient's agreement to the conference; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and
f. discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
g. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in mental health case conference items 973, 975 and 986, the provider must:

a. explain to the patient the nature of a mental health case conference, and ask for their agreement to the prescribed medical practitioner's participation in the conference; and
b. record the patient's agreement to the prescribed medical practitioner's participation; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual medical practitioner

Items 969-986 should generally be undertaken by the patient's usual medical practitioner. This is a prescribed medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Mental health case conference team members

The case conference must be organised by a medical practitioner (GP, prescribed medical practitioner or consultant physician in their specialty of paediatrics or psychiatry) and involve at least two other members of the multidisciplinary case conference team providing different kinds of treatment to the patient. Participating providers must be invited to attend by the organising practitioner.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

The patient should be given the option to attend the case conference, however may choose not to do so. Family members or carers, as well as other individuals providing support to the patient (such as a close friend, counsellor, teacher or peer worker) can also attend the case conference if the patient has agreed. However, these individuals do not count towards the minimum number of providers required.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Claiming frequency

It is expected that a patient would not normally require more than 4 case conferences in a 12-month period.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Further sources of information

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

AN.10.1 Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each optometrical service. The services provided by participating optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations* (as amended).

If the fee is greater than the Medicare benefit, optometrists participating in the scheme are to inform the patient of the Medicare benefit payable for the item, at the time of the consultation and that the additional fee will not attract benefits.

Medicare benefits are payable at 85% of the Schedule fee for services rendered.

Medicare Safety Nets

The Medicare safety net provides families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net (EMSN).

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee.

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are indexed on 1 January each year.

Individuals are automatically registered with the Services Australia for the safety nets, however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from Services Australia, or completed at www.servicesaustralia.gov.au. If you have already registered it is important to ensure your details are up to date.

Further information on the Medicare safety nets is available at https://www.servicesaustralia.gov.au/medicare-safety-nets.

Limiting rule for patient claims

Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Release of prescription

Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by any person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient, other than attendances provided by vocationally or non-vocationally trained general practitioners. The aftercare period includes all post-operative treatment, when provided by a medical specialist, consultant physician or optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances unrelated to the operation provided by a vocationally or non-vocationally registered general practitioner in the aftercare period can also attract Medicare benefits. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and the receipt issued to the patient should clearly indicate the fee is non-rebatable.

Single Course of Attention

A reference to a single course of attention means:

(a) In the case of items 10905 to 10918, and old item 10900 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with 08 Referrals

For the purposes of item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefits under item 10905.

The optometrist claiming the item 10905 service is obliged to retain the written referral for a period of twenty-four months.

Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)

A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Comprehensive initial consultations (items 10910 and 10911)

There are two new MBS items for comprehensive initial consultation that have been introduced. Item 10910 has been introduced for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Item 10911 has been introduced for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

However, a benefit is payable under item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (Short consultation) applies.

Significant change in visual function requiring comprehensive re-evaluation (item 10912)

Significant changes in visual function which justify the charging of item 10912 could include documented changes of:

· vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)

· visual fields or previously undetected field loss

· binocular vision

· contrast sensitivity or previously undetected contrast sensitivity loss.

New signs or symptoms requiring comprehensive re-evaluation (item 10913)

When charging item 10913 the optometrist should document the new signs or symptoms suffered by the patient on the patient's record card.

Progressive disorder requiring comprehensive re-evaluation (item 10914)

When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)

Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by item 10918.

Contact lens consultations (items 10921 to 10930)

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

For claims under items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36 month period.

Domiciliary visits (items 10931 - 10933)

Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 - 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

- the patient's home;

- a residential aged care facility as defined by the *Aged Care Act 1997;* or

- an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient's request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Items 10931 - 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941. The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the appropriate consultation item (excluding items 10916, 10932, 10933, 10940 or 10941). If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the appropriate consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be

billed item 10932 as well as the appropriate consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the appropriate consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service.

Computerised Perimetry Services (items 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, 10931, 10932 or 10933. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services in any twelve month period may be provided.

Low Vision Assessment (item 10942)

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Children's vision assessment (item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an

eligible child. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Removal of an embedded corneal foreign body (item 10944)

Item 10944 has been introduced for the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial), method of removal and the magnification. Similarly, with rust ring removal, the optometrist should document the method of removal and the magnification.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body or rust ring has not been completely removed, benefits are only payable under item 10916.

AN.14.2 Heart health assessment provided by general practitioners and prescribed medical practitioners

Item 699 and 177 may be used to undertake a heart health assessment, lasting at least 20 minutes, by a general practitioner (GPs see GN.4.13) or prescribed medical practitioner (PMPs see AN.7.1) to support patients with cardiovascular disease, or patients at risk of developing cardiovascular disease (CVD). Unless indicated otherwise, the term medical practitioner in this note includes both a general practitioner providing a service under item 699 or a prescribed medical practitioner providing a service under item 177.

The items provide patients with a comprehensive assessment of their cardiovascular health, identification of any physical or lifestyle-related risks to their cardiovascular health, and a comprehensive preventive health care plan to improve their cardiovascular health. The assessment may include auscultation of the patient's heart, where clinically relevant.

The heart health assessment item can be claimed once per patient in a 12-month period. The heart health assessment items cannot be claimed if a patient has had a health assessment service, excluding an Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715, 228, 92004, 92011), in the previous 12 months.

This item is available to all Medicare eligible patients aged 30 years and over who would benefit from an assessment of this type. The intention of this item is to identify CVD in people not known to have CVD.

The absolute cardiovascular disease risk is calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at 'http://www.cvdcheck.org.au/calculator/'.

Revision of the Australian Guidelines for the management of absolute cardiovascular disease risk (published in 2012) are currently underway (ACDPA | Absolute CVD risk guideline update), in the meantime resources on risk assessment can be found at ACDPA | Resources. Medical practitioners can also refer to the RACGP's 'National Guide to a Preventative Assessment for Aboriginal and Torres Strait Islander People' to complete this assessment.

Heart health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

Before a health assessment is commenced, the patient (and/or the patient's parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether they consent to the health assessment being performed. In cases where the patient is not capable of

giving consent, consent must be given by the patient's parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

The heart health assessment may only be provided by a general practitioner (699) or prescribed medical practitioner (177).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the heart health assessment items, 'usual doctor' means the general practitioner, or a prescribed medical practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months.

A health assessment should not take the form of a health screening service.

A copy of the heart health assessment must be retained for a period of two years after the date of service.

MBS heart health assessment items must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the heart health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Heart health assessment items do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, heart health assessment items can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Medicare bulk billing incentive items can be claimed in conjunction with any heart health assessment for eligible patients, provided the conditions of item are met.

AN.15.1 Mental Health Case Conferences

Items 930, 933, 935, 937, 943, 945 provide rebates for GPs to organise and coordinate, or participate in, mental health case conferences. They apply for a patient who is being treated under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative (Better Access) or an eating disorder treatment and management plan (EDTMP).

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient. A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and

- assesses whether previously identified outcomes (if any) have been achieved.

PATIENT ELIGIBILITY

Case conferences using these new MBS items can be held for patients who have been referred for treatment under Better Access or have an active eating disorder treatment and management plan.

Patients can be referred for treatment under Better Access by a:

- GP or OMP under a mental health treatment plan or psychiatrist assessment and management plan,
- psychiatrist, or
- paediatrician.

Treated under Better Access means a patient has been referred for a:

- a focussed psychological strategies service delivered by a GP, OMP, psychologist, social worker or occupational therapist, or
- psychological therapy service delivered by a clinical psychologist

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 930, 933 and 935, the provider must:

a. explain to the patient the nature of a mental health case conference and ask for their agreement to the conference taking place; and
b. record the patient's agreement to the conference; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and
f. discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
g. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in mental health case conference items 937, 943 and 945, the provider must:

a. explain to the patient the nature of a mental health case conference and ask for their agreement to the general practitioner's participation in the conference; and
b. record the patient's agreement to the general practitioner's participation; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual general practitioner

Items 930-945 should generally be undertaken by the patient's usual general practitioner. This is a general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Mental health case conference team members

The case conference must be organised by a medical practitioner (GP, OMP or consultant physician in their specialty of paediatrics or psychiatry) and involve at least two other members of the multidisciplinary case conference team providing different kinds of treatment to the patient. Participating providers must be invited to attend by the organising practitioner.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

The patient should be given the option to attend the case conference, however may choose not to do so. Family members or carers, as well as other individuals providing support to the patient (such as a close friend, counsellor, teacher or peer worker) can also attend the case conference if the patient has agreed. However, these individuals do not count towards the minimum number of providers required.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Claiming frequency

It is expected that a patient would not normally require more than 4 case conferences in a 12 month period.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Further sources of information

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

AN.15.2 Mental Health Case Conferences - Psychiatrists and Paediatricians

A range of items are available for consultant physicians in their speciality of paediatrics or psychiatry to organise and co-ordinate, or participate in, mental health case conferences. They apply for a patient who is being treated under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative (Better Access) or an eating disorder treatment and management plan (EDTMP).

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient. A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

PATIENT ELIGIBILITY

Case conferences using these new MBS items can be held for patients who have been referred for treatment under Better Access or have an active eating disorder treatment and management plan.

Patients can be referred for treatment under Better Access by a:

- GP or OMP under a mental health treatment plan or psychiatrist assessment and management plan,
- psychiatrist, or
- paediatrician.

Treated under Better Access means a patient has been referred for a:

- focussed psychological strategies service delivered by a GP, OMP, psychologist, social worker or occupational therapist, or
- psychological therapy service delivered by a clinical psychologist

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 946, 948 and 959, the provider must:

a. explain to the patient the nature of a mental health case conference and ask for their agreement to the conference taking place; and
b. record the patient's agreement to the conference; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and
f. discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
g. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in mental health case conference items 961, 962 and 964, the provider must:

a. explain to the patient the nature of a mental health case conference and ask for their agreement to the general practitioner's participation in the conference; and
b. record the patient's agreement to the general practitioner's participation; and
c. record the day on which the conference was held, and the times at which the conference started and ended; and
d. record the names of the participants; and
e. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Mental health case conference team members

The case conference must be organised by a medical practitioner (GP, OMP or consultant physician in their specialty of paediatrics or psychiatry) and involve at least two other members of the multidisciplinary case conference team providing different kinds of treatment to the patient. Participating providers must be invited to attend by the organising practitioner.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

The patient should be given the option to attend the case conference, however may choose not to do so. Family members or carers, as well as other individuals providing support to the patient (such as a close friend, counsellor, teacher or peer worker) can also attend the case conference if the patient has agreed. However, these individuals do not count towards the minimum number of providers required.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Claiming frequency

It is expected that a patient would not normally require more than 4 case conferences in a 12 month period.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

Further sources of information

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

AN.20.1 Provision of Focussed Psychological Strategies Services by Eligible GPs to a Person Other than the Patient (2739, 2741, 2743, 2745, 91859, 91861, 91864 and 91865)

OVERVIEW

The purpose of these MBS items is to enable eligible GPs to involve another person in a patient's treatment, under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, where:

- the eligible GP providing the service determines it is clinically appropriate,
- the patient consents for the service to be provided to the other person as part of their treatment,
- the service is part of the patient's treatment, and
- the patient is not in attendance.

These MBS items recognise the important role another person, such as a family member or carer, can play in supporting patients with mental illness, and the benefits that can result from involving them in treatment.

Under these MBS items, Medicare rebates are available to a patient for up to two services provided to another person per calendar year. Any services delivered using these items count towards the patient's course of treatment and calendar year allocations under Better Access. For further information on patient allocations, please see explanatory note AN.0.56.

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

SERVICES ATTRACTING MEDICARE REBATES

MBS items

There are eight MBS items for the provision of focussed psychological strategies (FPS) health services to a person other than the patient by eligible GPs:

- 2739, 2741, 2743 and 2745 for provision of in person FPS services by a GP;
- 91859 and 91861 for provision of telehealth FPS services by a GP; and
- 91864 and 91865 for provision of phone FPS services by a GP.

Telehealth services are the preferred approach for substituting a face-to-face consultation. However, eligible GPs will also be able to offer phone (audio-only) services if video is not available or appropriate. As outlined above, there are separate items available for phone services.

To claim these MBS items the eligible GP must meet the provider eligibility requirements for the delivery of FPS services. For further information, please see explanatory note AN.0.57.

Eligible focussed psychological strategies services

A range of acceptable strategies have been approved for use by eligible GPs utilising FPS items. For further information, please see explanatory note AN.0.57.

Eligible GPs must use their professional judgement to determine what would be an appropriate FPS service to deliver to another person as part of the patient's treatment within the approved list of FPS.

Publicly funded services

These MBS items do not apply for services provided by any other Commonwealth or state funded services, or provided to an admitted patient of a hospital, unless there is an exemption under subsection 19(2) of the *Health Insurance Act 1973*.

SERVICE LIMITATIONS

Medicare rebates are available to a patient for up to two services provided to another person per calendar year. The two services may consist of:

- GP items: 2739, 2741, 2743, 2745, 91859, 91861, 91864 and 91865
- Other Medical Practitioner items: 309, 311, 313, 315, 91862, 91863, 91866 and 91867
- Clinical psychologist items: 80002, 80006, 80012, 80016, 91168, 91171, 91198 and 91199
- Psychologist items: 80102, 80106, 80112, 80116, 91174, 91177, 91200 and 91201
- Occupational therapist items: 80129, 80131, 80137, 80141, 91194, 91195, 91202 and 91203
- Social worker items: 80154, 80156, 80162, 80166, 91196, 91197, 91204 and 91205

Any services delivered using these MBS items count towards:

- the maximum session limit for each course of treatment under Better Access, and
- the patient's calendar year allocation for individual services under Better Access.

For further information on the maximum session limits for each course of treatment and maximum calendar year allocation, please see explanatory note AN.0.56.

CLAIMING REQUIREMENTS

Determining service is clinically appropriate

The eligible GP providing the service must use their professional judgment to determine it is clinically appropriate, and would form part of the patient's treatment, to provide a FPS service to another person.

This determination must be recorded in writing in the patient's records.

Obtaining and recording patient consent to deliver the service

The patient must consent to the other person receiving a FPS service using these MBS items. The eligible GP providing the service must:

- Explain the service to the patient.
- Obtain the patient's consent for the service to be provided to the other person as part of the patient's treatment.
- Make a written record of the patient's consent.

The patient may withdraw their consent at any time.

In the case of a child, the general laws relating to consent to medical treatment apply. These may differ between states and territories, and the GP should be aware of the requirements in the relevant state or territory.

Service must be part of the patient's treatment

Any service delivered using these MBS items must be part of the patient's treatment. These MBS items are not for the purposes of providing mental health treatment to the person receiving the service. Should that person also

require mental health treatment the patient MBS items should be claimed (where all the requirements for the relevant item descriptor have been met).

Patient is not in attendance

These MBS items are for eligible GPs to provide services to another person when the patient is not in attendance. If the patient is in attendance, the GP can consider whether the requirements of the patient MBS items for delivering Better Access services have been met. For further information, please see explanatory note AN.0.57.

Course of treatment

These services may be accessed at any stage of a patient's course of treatment and do not need to be accessed consecutively, provided no more than two services are delivered to another person and delivering these services does not exceed the maximum allowed for the patient in a course of treatment or calendar year under Better Access.

ADDITIONAL INFORMATION

Out-of-pocket expenses and Medicare safety net

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Checking the number of services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm the number of mental health services already claimed by the patient during the calendar year. Eligible GPs can call Services Australia on 132 150 to check this information, while patients can call on 132 011.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia Medicare Provider Enquiry Line on 132 150.

AN.33.1 TAVI CASE CONFERENCE - (ITEMS 6080 AND 6081)

Items 6080 and 6081 apply to a TAVI Case Conference organised to discuss a patient's suitability to receive the service described in items 38495 or 38514 for Transcatheter Aortic Valve Implantation (TAVI).

For items 6080 and 6081 a TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in items 38495 or 38514 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in items 38495 or 38514, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in item 38495 or item 38514; and

(d) the particulars of the assessment and recommendation are recorded in writing.

TAVI Practitioner

For items 6080 and 6081 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under items 38495 or 38514.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

Coordination of a TAVI Case Conference

For item 6080, coordination means undertaking all of the following activities in relation to a TAVI Case Conference:

a. ensuring that the patient is aware of the purpose and nature of the patient's TAVI Case Conference and has consented to their TAVI Case Conference;
b. recording the day the conference was held, and the times the conference started and ended;
c. recording the names of the participants of the conference;
d. provision of expertise to inform the recommendation resulting from the case conference;
e. recording minutes of the TAVI Case Conference including the recommendation resulting from the conference;
f. ensuring that the patient is aware of the recommendation.

Attendance at a TAVI Case Conference

For item 6081, attendance means undertaking all of the following activities in relation to a TAVI Case Conference:

a. retaining a record of the day the conference was held, and the times the conference started and ended;
b. retaining a record of the names of the participants;
c. provision of expertise to inform the recommendation resulting from the case conference;
d. retaining a record of the recommendation resulting from the conference.

General requirements

The TAVI Case Conference must be arranged in advance, within a time frame that allows for all the participants to attend. A TAVI Case Conference is to last at least 10 minutes and a minimum of three suitable participants (as defined under the item requirements), must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the TAVI Case Conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the assessment of suitability; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the TAVI Practitioner coordinating the TAVI Case Conference should ensure the patient has been:

- Informed that their medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Informed that they may incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating TAVI Practitioner or the attending interventional cardiologist, cardiothoracic surgeon or independent specialist or consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for attendance by other medical practitioners at a TAVI Case Conference.

It is expected that a patient would not normally require more than one TAVI Case Conference in determining suitability for the services described in items 38495 or 38514. As such, item 6080 is only payable once per patient in a five year period. Item 6081 is payable only twice per patient in a five year period.

Items 6080 and 6081 do not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.35.1 Flag fall amount for residential aged care facility attendance by a general practitioner

Medicare item 90001 provides a flag fall fee for the initial attendance by a general practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit.

The Medicare benefit for the single flag fall fee and the associated general consultation (Levels A to E) applies only for patients within a RACF who have a general consultation with a doctor in person.

If doctors do not bill the single flag fall fee, the benefit will not be paid.

If a doctor has to return to the RACF facility twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another flag fall fee would apply per subsequent RACF visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS items 90001 is not to be used with existing derived fee services such as for afterhours, urgent afterhours, or telehealth services. The bulk billing incentive only applies to the attendance item, not to the single flag fall fee.

AN.35.2 Flag fall amount for residential aged care facility attendance by a medical practitioner or prescribed medical practitioner

Medicare item 90002 provides a flag fall fee for the initial attendance by a medical practitioner or prescribed medical practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit.

The Medicare benefit for the single flag fall fee and the associated general consultation (Levels A to E) applies only for patients within a RACF who have a general consultation with a doctor in person.

If doctors do not bill the single flag fall fee, the benefit will not be paid.

If a doctor has to return to the RACF facility twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another flag fall fee would apply per subsequent RACF visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS items 90002 is not to be used with existing derived fee services such as for afterhours, urgent afterhours, or telehealth services. The bulk billing incentive only applies to the attendance item, not to the single flag fall fee.

AN.36.1 Eating Disorders General Explanatory Notes

Eating Disorders General Explanatory Notes (items 90250-90257, 90260-90261, 90264-90267, 90271-90278; 92182, 92184, 92186 and 92188; 92194, 92196, 92198 and 92200)

This note provides a general overview of the full range of 1 November 2019 eating disorders items and supporting information more specifically on the Category 1 – Professional Attendances: Group A36 – Eating Disorders Services (90250-90257, 90260-90261, 90264-90267; 90271-90278, 92182, 92184, 92186 and 92188; 92194, 92196, 92198 and 92200).

It includes an overview of the items, model of care, patient eligibility, and links to other guidance and resources.

Overview

All 1 November 2019 Eating Disorders items:

The Eating Disorders items define services for which Medicare rebates are payable where service providers undertake assessment and management of patients with a diagnosis of anorexia nervosa and patients with other specified eating disorder diagnoses who meet the eligibility criteria (see – patient eligibility). It is expected that there will be a multidisciplinary approach to patient management through these items.

The items mean eligible patients are able to receive a Medicare rebate for development of an eating disorders treatment plan by a medical practitioner in general practice (Group A36, subgroup 1 and Group A40 subgroup 21), psychiatry or paediatrics (Group A36, subgroup 2 and Group A40, subgroup 23), psychiatry or paediatrics (Group A36, subgroup 2 and Group A40, subgroup 23). Patients with an eating disorders treatment and management plan (EDP) will be eligible for comprehensive treatment and management services for a 12 month period, including:

- Up to 20 dietetic services under items 110954, 82350, 93074 and 93108.
- Up to 40 eating disorder psychological treatment services (EDPT service).
- Review and ongoing management services to ensure that the patient accesses the appropriate level of intervention (Group A36, subgroup 3).

An EDPT service includes mental health treatment services which are provided by an allied health professional or a medical practitioner in general practice with appropriate mental health training. These treatment services include:

- Medicare mental health treatment services currently provided to patients under the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS ('Better Access') initiative.
    - This includes medical practitioner items 2721, 2723, 2725, 2727, 283, 285, 286, 287 and
    - Their equivalent telehealth and phone items 91818, 91819, 91820, 91844, 91821 and 91845
    - This includes allied health items in Groups M6 and M7 of Category 8; and
- Items for EDPT services provided by suitably trained medical practitioners in general practice (items 90271, 90278, 92182, 92184, 92186, 92188, 92194, 92198 and 92200)
- new items for EDPT services provided by eligible clinical psychologists (items 82352, 82354, 82355, 82357-82359; 93076, 93079, 93110 and 93113), eligible psychologists (items 82360, 82362-82363, 82365-82367; 93084, 93087, 93118 and 93121), eligible occupational therapists (items 82368, 82370-82371, 82373-82375; 93092, 93095, 93126 and 93129) and eligible social workers (items 82376, 82378-82379, 82381-82383; 93100, 93103, 93134 and 93137)

For the purpose of the 40 EDPT count; eating disorder psychological treatment service includes a service under

provided under the following items: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 92182, 92184, 92186, 92188, 92194, 92196, 92198 and 92200, 2721, 2723, 2725, 2727, 283, 285, 286, 287, 91818, 91819, 91820 91821; 91842, 91843, 91844 and 91845 and items in Groups M6, M7 and M16 (excluding items 82350, 93074 and 93108)

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Patient Eligibility

The Eating Disorder items are available to eligible patients in the community. These items do not apply to services provided to admitted (in-hospital) patients.

The referring practitioner is responsible for determining that a patient is eligible for an EDP and therefore EDPT and dietetic services.

'Eligible patient' defines the group of patients who can access the new eating disorder services. There are two cohorts of eligible patients.

1. Patients with a clinical diagnosis of anorexia nervosa; or
2. Patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:
    i. bulimia nervosa;
    ii. binge-eating disorder;
    iii. other specified feeding or eating disorder.

The eligibility criteria, for a patient, is:

a. a person who has been assessed as having an Eating Disorder Examination Questionnaire score of 3 or more; and
b. the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
c. a person who has at least two of the following indicators:
    i. clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;
    ii. current or high risk of medical complications due to eating disorder behaviours and symptoms;
    iii. serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
    iv. the person has been admitted to a hospital for an eating disorder in the previous 12 months;
    v. inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

Practitioners should have regard to the relevant diagnostic criteria set out in the Diagnostic and Statistical Manual of the American Psychiatric Association – Fifth Edition (DSM-5)

Practitioners can access the Eating Disorder Examination Questionnaire at https://www.credo-oxford.com/pdfs/EDE_17.0D.pdf

The Eating Disorders Items Stepped Model of Care

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders that comprise:

- assessment and treatment planning
- provision of and/or referral for appropriate evidence based eating disorder specific treatment services by allied mental health professionals and provision of services by dietitians

- review and ongoing management items to ensure that the patient accesses the appropriate level of intervention.

The Stepped Model

‘STEP 1’ – PLANNING (trigger Eating Disorders pathway) 90250-90257; 92146 to 92153 and 90260 or 90261

An eligible patient receives an EDP developed by a medical practitioner in general practice (items 90250-90257), psychiatry (items 90260) or paediatrics (items 90261).

‘STEP 2’ – COMMENCE INITIAL COURSE OF TREATMENT (psychological & dietetic services)

Once an eligible patient has an EDP in place, the 12 month period commences, and the patient is eligible for an initial course of treatment up to 20 dietetic services and 10 eating disorder psychological treatment (EDPT) services. A patient will be eligible for an additional 30 EDPT services in the 12 month period, subject to reviews from medical practitioners to determine appropriate intensity of treatment.

‘STEP 3' – CONTINUE ON INITIAL COURSE OF TREATMENT 90264-90267 (managing practitioner review and progress up to 20 EDPT services)

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90267; 92170, 92171, 92175 and 92177), to assess the patient’s progress against the EDP or update the EDP, before they can access more than 10 EDPT services. This is known as the ‘first review’. The first review should be provided by the patient’s managing practitioner, where possible.

‘STEP 4’ FORMAL SPECIALIST AND PRACTITIONER REVIEW 90266 and 90267 (continue beyond 20 EDPT services)

A patient must have two additional reviews before they can access more than 20 EDPT services. One review (the ‘second review’) must be performed by a medical practitioner in general practice (who is expected to be the managing practitioner), and the other (the ‘third review’) must be performed by a paediatrician (90267 or 92173) or psychiatrist (90266 or 92172). Should both recommend the patient requires more intensive treatment, the patient would be able to access an additional 10 EDPT services in the 12 month period. These reviews are required to determine that the patient has not responded to treatment at the lower intensity levels.

The patient’s managing practitioner should be provided with a copy of the specialist review.

The specialist review by the psychiatrist or paediatrician can occur at any point before 20 EDPT services. The practitioner should refer the patient for specialist review as early in the treatment process as appropriate. If the practitioner is of the opinion that the patient should receive more than 20 EDPT services, the referral should occur at the first practitioner review (after the first course of treatment) if it has not been initiated earlier.

Practitioners should be aware that the specialist review can be provided via telehealth (92172 and 92173). Where appropriate, provision has been made for practitioner participation on the patient-end of the telehealth consultation.

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90267), to assess the patient’s progress against the EDP or update the EDP, before they can access the next course of treatment.

‘STEP 5’ ACCESS TO MAXIMUM INTENSITY OF TREATMENT 90266-90267 (continue beyond 30 EDPT services)

To access more than 30 EDPT treatment services in the 12 month period, patients are required to have an additional review (the ‘fourth review’) to ensure the highest intensity of treatment is appropriate. Subject to this review, a patient could access the maximum of 40 EDPT treatment services in a 12 month period. The fourth review should be provided by the patient’s managing practitioner, where possible.

An Integrated Team Approach

A patient's family and/or carers should be involved in the treatment planning and discussions where appropriate. The family can be involved in care options throughout the diagnosis and assessment, and are usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.

The National Standards for the safe treatment of eating disorders specify a multi-disciplinary treatment approach that provides coordinated psychological, physical, behavioural, nutritional and functional care to address all aspects of eating disorders. People with eating disorders require integrated inter-professional treatment that is able to work within a framework of shared goals, care plans and client and family information. Frequent communication is required between treatment providers to prevent deterioration in physical and mental health (RANZCP Clinical Guidelines: Hay et al., 2014). Consider regular case conferencing to ensure that the contributing team members are able to work within a shared care plan and with client and carers to achieve best outcomes.

Clinical guidelines and other resources

It is expected that the consultants providing services under these items should have the appropriate skills, knowledge and experience to provide eating disorders treatment. However, there are a number of resources which may be of assistance to practitioners in supporting and developing EDP and EDPT plans, these include:

- The Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines
- ANZAED eating disorder treatment principles and general clinical practice and training standards:

Heruc, G., Hurst, K., Casey, A. et al. ANZAED eating disorder treatment principles and general clinical practice and training standards. J Eat Disord 8, 63 (2020).

- ANZAED practice and training standards for dietitians providing eating disorder treatment:

Heruc, G., Hart, S., Stiles, G. et al. ANZAED practice and training standards for dietitians providing eating disorder treatment. J Eat Disord 8, 77 (2020).

- ANZAED practice and training standards for mental health professionals providing eating disorder treatment:

Hurst, K., Heruc, G., Thornton, C. et al. ANZAED practice and training standards for mental health professionals providing eating disorder treatment. J Eat Disord 8, 58 (2020).

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

National Eating Disorders Collaboration Eating Disorders: a professional resources for general practitioners available at www.nedc.com.au

Eating Disorders Training

It is expected that practitioners who are providing services under these items have appropriate training, skills and experience in treatment of patients with eating disorders and meet the national workforce core competencies for the safe and effective identification of and response to eating disorders more information available at National Eating Disorders Collaboration

Training Services

Practitioners should contact their professional organisation to identify education and training which may assist to practitioners to gain the skills and knowledge to provide services under these items.

The following organisations provide training which may assist practitioners to meet the workforce competency standards:

- The Australia and New Zealand Academy of eating disorders (ANZAED) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD
- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

This list is not exhaustive but has been included to provide examples on the types of training available which may assist practitioners to upskill in this area.

AN.36.2 Eating Disorders Treatment and Management Plans Explanatory Notes

Eating Disorders Treatment and Management Plans Explanatory Notes (items 90250-90257 and 90260-90261)

This note provides information on Eating Disorders Treatment and Management Plan (EDP) items and should be read in conjunction with the Eating Disorders General Explanatory Notes

Eating Disorder Treatment Plan (EDP) items overview

The EDP items define services for which Medicare rebates are payable where practitioners undertake the development of a treatment and management plan for patients with a diagnosis of anorexia nervosa and patients with other specified eating disorder diagnoses who meet the eligibility criteria.

The EDP items trigger eligibility for items which provide delivery of eating disorders psychological treatment (EDPT) services (up to a total of 40 psychological services in a 12 month period) and dietetic services (up to a total of 20 in a 12 Month period).

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. Eating Disorders treatment services are not available to the patient if the EDP has expired.

Preparation of the EDP must include:

- discussing the patient's medical and psychological health status with the patient and if appropriate their family/carer;
- identifying and discussing referral and treatment options with the patient and their family/carer where appropriate, including identification of appropriate support services;
- agreeing goals with the patient and their family/carer where appropriate - what should be achieved by the treatment - and any actions the patient will take;
- planning for the provision of appropriate patient and family/carer education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up;
- documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date in the patient's plan;
- Discussing and organising the appropriate reviews throughout the patient's treatment; and
- discussing the need for the patient to be reviewed to access a higher intensity of EDPT services in a 12 month period.

Preparing a Medical practitioner in general practice Eating Disorder Treatment & Management Plan (items 90250-90257)

Who can provide the service

Items in subgroup 1 of Group A36 can be rendered by a medical practitioner in general practice. This includes:

- Medical practitioners who can render a general practitioner service in Group A1 of the MBS (see note AN.0.9 for the types of medical practitioners). These medical practitioners can render a 'general practitioner' service for items in subgroup 1 of Group A36.
- Medical practitioners who are not general practitioners, specialists or consultant physicians. These medical practitioners can render a 'medical practitioner' service for items in subgroup 1 of Group A36.

What is Involved - Assess and Plan

It is expected that the practitioner developing the EDP has either performed or reviewed the assessments and examinations required to make a judgement that the patient meets the eligibility criteria for accessing these items.

Items 90250-90257 provide services for development of the eating disorder treatment and management plan. Where a comprehensive physical examination is performed, either on the same occasion or different occasion, the appropriate item could be claimed provided the time taken performing the assessment is not included in the time for producing the plan, or time producing the EDP is not included in the time for assessment.

It is emphasised that it is best practice for the practitioner to perform a comprehensive physical assessment to facilitate ongoing patient management and monitoring of medical and nutritional status.

Patient Assessment

An assessment of a patient with an eating disorders includes:

- taking relevant history (biological, psychological, social, including family/carer support);
- eating disorder diagnostic assessment;
- medical review including physical examination and relevant tests;
- conducting an assessment of mental state, including identification of comorbid psychiatric conditions;
- an assessment of eating disorder behaviours;
- an assessment of associated risk and any medical co-morbidity, including as assessment on how this impacts on the patients functioning and activities of daily living;
- an assessment of family and/or carer support; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

Risk assessment for a patient with an eating disorder should include identification of:

- medical instability and risk of hospitalisation;
- level of psychological distress and suicide risk;
- level of malnourishment;
- identification of psychiatric comorbidity;
- level of disability;
- duration of illness;
- response to earlier evidence-based eating disorders treatment;
- level of family/carer support.

It should be noted that the patient's EDP should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

Preparing a Consultant Psychiatrist Eating Disorder Treatment & Management Plan (90260-90261)

Who can provide the service

Items in subgroup 2 of Group 36 can be rendered by consultant psychiatrists (items 90260 and 90261).

What is Involved – Assess and Plan

Items 90260-90261 provide access to specialist assessment and treatment planning. It is expected that items will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP for an assessment and management plan, but it is not possible for the consultant to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, other appropriate consultation items may be used. In those circumstances where the consultant undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring practitioner with an assessment and management plan. It is expected that such occurrences would be unusual for the purpose of diagnosis under item 90260.

Patient Assessment

In order to facilitate ongoing patient focussed management, an assessment of the patient must include:

- administering an outcome measurement tool during the assessment and review stages of treatment, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner;
- conducting a mental state examination;
- taking relevant history (biological, psychological, behavioural, nutritional, social);
- assessing associated risk and any co-morbidity; and
- making a psychiatric diagnosis for conditions meeting the eligibility criteria.

Risk assessment for a patient with an eating disorder should include identification of:

- medical instability and risk of hospitalisation;
- level of psychological distress and suicide risk;
- level of malnourishment;
- identification of psychiatric comorbidity;
- level of disability;
- duration of illness;
- response to earlier evidence-based eating disorders treatment;
- level of family/carer support.

Where a consultant psychiatrist provides an EDP service, the service must also include:

- administering an outcome measurement tool, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training; and
- conducting a mental state examination.

Consultation with the patient's managing practitioner

A written copy of the EDP should be provided to the patient's managing practitioner, within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the managing practitioner may be appropriate.

Additional Claiming Information (general conditions and limitations)

Patients seeking rebates for items 90250-90257 and 90260-90261 will not be eligible if the patient has had a claim within the last 12 months.

Items 90250-90257 cannot be claimed with Items 2713, 279, 735, 758, 235 and 244. Items 90261 cannot be claimed with Items 110, 116, 119, 132, 133.

Consultant psychiatrist and paediatrician EDP items 90260-90261 do not apply if the patient does not have a referral within the period of validity.

Before proceeding with the EDP the medical practitioner must ensure that:

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

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

The medical practitioner must offer the patient a copy of the EDP and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the EDP, or relevant parts of the plan, to other providers involved in the patient's treatment.

The medical practitioner EDP cover the service of developing an EDP. A separate consultation item can be performed with the EDP if the patient is treated for an unrelated condition to their eating disorder. Where a separate consultation is performed, it should be annotated separately on the patient's account that a separate consultation was clinically required/indicated.

All consultations conducted as part of the EDP must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to the medical practitioner in provision of this care.

Additional Claiming Information (interaction with Chronic Disease Management and Better Access)

It is preferable that wherever possible patients have only one plan for primary care management of their disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a CDM Plan, and to manage their eating disorder through an EDP. In this case, both items can be used. Where the patient receives dietetic services under the CDM arrangements (item 10954), these services will count towards the patients maximum of 20 dietetic services in a 12 month period.

Where a patient has other psychiatric comorbidities, these conditions should be managed under the EDP. Once a patient has a claim for an EDP, the patient should not be able to have a claim for the development or review of a Mental Health Treatment plan by a GP (items 2700, 2701, 2715 and 2717) or medical practitioner in general practice (items 272, 276, 281 and 282) within 12 months of their EDP unless there are exceptional circumstances.

For the purpose of the 40 EDPT count; eating disorder psychological treatment service includes a service under provided under the following items: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372 and items in Groups M6, M7 and M16 (excluding item 82350).

AN.36.3 Eating Disorders Treatment and Management Plan Reviews

Eating Disorders Treatment and Management Plan Reviews (items 90264-90267)

This note provides information on Eating Disorders Treatment and Management Plan (EDP) review items and should be read in conjunction with the AN.36.1 Eating Disorders General Explanatory Notes and the AN.36.2 Eating Disorders Treatment and Management Plans Explanatory Notes

Eating Disorder Treatment Plan review (EDR) items overview

The EDR items define services for which Medicare rebates are payable where practitioners undertake to review the efficacy of the patient's eating disorder treatment and management plan (EDP). This includes modifying the patient's plan, where appropriate, to improve patient outcomes. The review services can be provided by medical practitioners working in general practice, psychiatry and paediatrics.

An EDR may be provided by the managing practitioner who prepared the patient's initial plan (or another practitioner in the same practice or in another practice where the patient has changed practices) and should include a systematic review of the patient's progress against the initial EDP (whether it was prepared by a GP, psychiatrist or paediatrician) and by completing the activities that must be included in a review (see below).

When to render an EDR review item

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP to assess the patient's progress against the EDP or update the EDP, as the patient is approaching the end of each course of treatment before they can access the next course of treatment.

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review after each course of treatment (see AN.36.1 Eating Disorders General Explanatory Notes).

Reviewing an Eating Disorders Treatment Plan

The EDR must include:

- recording the patient's agreement for this service;
- referral to a psychiatrist or paediatrician for review under items 90266-90267, if this has not been initiated at an earlier stage;
- a review of the patient's progress against the goals outlined in the EDP, including discussion with the patient/and or their family/carer as to whether the EDPT services are meeting their needs;
- modification of the documented EDP if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- reviewing reports back from the allied mental health professional on the patient's response to treatment and documenting a recommendation on whether patient should continue with another course of EDPT services with that health professional or another health professional.

Where a consultant psychiatrist or paediatrician provides an EDR, the consultant physician must give the referring practitioner a copy of the diagnosis and the revised EDP within 2 weeks after the attendance. Where a consultant psychiatrist provides an EDR service, the review must also include:

- administering an outcome measurement tool, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training; and
- conducting a mental state examination.

Note: It is expected there will be other consultations between the patient and the managing practitioner as part of ongoing patient and medical management, including the ordering and reviewing of the required testing for

monitoring the patients' medical and nutritional status. All other ongoing patient reviews should be claimed under the appropriate item.

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

To provide an EDR service in items 90264-90267, the patient must have had an EDP 90250-90257 or 90260-90261 in the previous 12 months.

If the EDP service has not yet been claimed, Services Australia will not be aware of the patient's eligibility. In this case the practitioner should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call Services Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Items 90264-90265 cannot be claimed with item 2713 and 279.

Consultant psychiatrist and paediatrician EDP items 90266-90267 do not apply if the patient does not have a referral within the period of validity.

Before proceeding with the EDR service the medical practitioner must ensure that:

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

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

The medical practitioner must offer the patient a copy of the reviewed EDP and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the revised EDP, or relevant parts of the plan, to other providers involved in the patient's treatment.

The medical practitioner EDR items cover the service of reviewing an EDP. A separate consultation item can be performed with the EDP if the patient is treated for an unrelated condition to their eating disorder. Where a separate consultation is performed, it should be annotated separately on the patient's account that a separate consultation was clinically required/indicated.

All consultations conducted as part of the EDP or review must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to the medical practitioner in provision of this care.

Additional Claiming Information (interaction with Better Access)

Items 90264-90265 for an EDR, performed by a medical practitioner working in general practice, should not be performed in association with a GP mental health consultation review service (item 2712 and 277).

AN.36.4 Eating Disorders Psychological Treatment (EDPT) Services

Eating Disorders Psychological Treatment (EDPT) services (90271-78; 92182, 92184, 92186, 92188; 92194, 92196, 92198 and 92200)

This note provides information on the Category 1 – Professional Attendances: Group A36 – Subgroup 4 (90271-90278) should be read in conjunction the AN.36.1 Eating Disorders General Explanatory Notes

Eating Disorder Psychological Treatment (EDPT) Services Overview

Provision of EDPT by a suitably trained medical practitioner in general practice (90271-90278;92182, 92184, 92186, 92188; 92194, 92196, 92198 and 92200) is for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

Patients seeking rebates for EDPT services must have had an EDP 90250-90257, 92146-92153, 90260 or 90261 in the previous 12 Months.

An 'eating disorder psychological treatment service' (EDPT) is defined in the AN.36.1 Eating Disorders General Explanatory Note. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Rendering an EDPT item

Who can provide the service

Items in subgroup 4 of Group A36 can be rendered by a medical practitioner in general practice with the required mental training. This includes:

- Medical practitioners who can render a general practitioner service in Group A1 of the MBS (see note AN.0.9 for the types of medical practitioners). These medical practitioners can render a 'general practitioner' service for items in subgroup 1 of Group A36. These doctors must have the mental health training requirements as specified below.
- Medical practitioners who are not general practitioners, specialists or consultant physicians. These medical practitioners can render a 'medical practitioner' service for items in subgroup 1 of Group A36. These doctors must have the mental health training requirements as specified below.

Mental health training

Medical practitioner in general practice who meets the training and skills requirements as determined by the General Practice Mental Health Standards Collaboration, and are entered on the Register as being eligible to render a focussed psychological strategy service, can render an eating disorders psychological treatment service.

Note: The General Practice Mental Health Standards Collaboration operates under the auspices of the Royal Australian College of General Practitioners.

What is Involved in an EDPT service

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review (an EDR item in subgroup 3 of A36) after each course of treatment (see AN.36.1 Eating Disorders General Explanatory Notes).

After each course of treatment, the relevant practitioners should provide the medical practitioner who is the managing the patient's EDP (where appropriate) with a written report.

A range of acceptable treatments has been approved for use by practitioners in this context. It is expected that professionals will have the relevant education and training to deliver these services. The approved treatments are:

- Family Based Treatment for Eating Disorders (EDs) (including whole family, Parent Based Therapy, parent only or separated therapy)
- Adolescent Focused Therapy for EDs
- Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)
- CBT-Anorexia Nervosa (AN) (CBT-AN)
- CBT for Bulimia Nervosa (BN) and Binge-eating Disorder (BED) (CBT-BN and CBT-BED)
- Specialist Supportive Clinical Management (SSCM) for EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for EDPT 90271-90278; 92182, 92184, 92186, 92188; 92194, 92196, 92198, 92200 must have had an EDP 90250-90257; 92146-92153 or 90260 and 90261 in the previous 12 months.

If the EDP service has not yet been claimed, the Services Australia will not be aware of the patient's eligibility. In this case the practitioner should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Services Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Other than Consultation Room (items 90272, 90274, 90276, 90278)

It is expected that this service would be provided only for patients who are unable to attend the practice.

AN.36.5 Eating Disorders Telehealth – Medical Practitioner in general practice

Eating Disorders Telehealth – Medical Practitioner in general practice (92182, 92184, 92186 and 92188)

This note provides telehealth supporting information for eating disorders items provided via telehealth by a medical practitioner in general practice and should be read in conjunction with Eating Disorders General Explanatory Notes.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple Attendances on the Same Day

In some situations, a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

AN.40.1 Specialist and Consultant Physician MBS Telehealth and Telephone attendance items

From 1 January 2022, a number of telehealth items were permanently added to the MBS.

The intent of these ongoing telehealth items is to allow practitioners to provide MBS attendances remotely (by videoconference or telephone) where it is safe and clinically appropriate to do so in accordance with relevant professional standards.

Providing telehealth services by videoconference is the preferred substitution for a face-to-face consultation. However, providers can provide a consultation via telephone where it is clinically relevant (and the service is covered by a relevant telephone item).

A list of the ongoing telehealth items and the equivalent face-to-face items can be found at Table 1.

Table 1 – Ongoing telehealth items and equivalent face to face services (out of hospital patients)

Service	Face-to-face items	Video items	Telephone items
Specialist Services			
Specialist. Initial attendance	104	91822	-

Specialist. Subsequent attendance	105	91823	91833
Consultant Physician Services			-
Consultant physician. Initial attendance	110	91824	-
Consultant physician. Subsequent attendance	116	91825	-
Consultant physician. Minor attendance	119	91826	91836
Consultant physician. Initial assessment, patient with at least 2 morbidities, prepare a treatment and management plan, at least 45 minutes	132	92422	-
Consultant physician, Subsequent assessment, patient with at least 2 morbidities, review a treatment and management plan, at least 20 minutes	133	92423	-
Specialist and Consultant Physician Services			
Specialist or consultant physician, develop a treatment and management plan, patient aged under 25, with an eligible disability	137	92141	-
Geriatrician Services			
Geriatrician, prepare an assessment and management plan, patient at least 65 years, more than 60 minutes	141	92623	-

Geriatrician, review a management plan, more than 30 minutes	143	92624	-
Consultant Psychiatrist services			
Consultant psychiatrist, develop a treatment and management plan, patient aged under 25, with a complex neurodevelopmental disorder (such as autism spectrum disorder), at least 45 minutes	289	92434	-
Consultant psychiatrist, prepare a management plan, more than 45 minutes	291	92435	-
Consultant psychiatrist, review management plan, 30 to 45 minutes	293	92436	-
Consultant psychiatrist, attendance, new patient (or has not received attendance in preceding 24 mths), more than 45 minutes	296	92437	-
Consultant psychiatrist. Consultation, not more than 15 minutes	300	91827	91837
Consultant psychiatrist. Consultation, 15 to 30 minutes	302	91828	91838
Consultant psychiatrist. Consultation, 30 to 45 minutes	304	91829	91839
Consultant psychiatrist. Consultation, 45 to 75 minutes	306	91830	-

Consultant psychiatrist. Consultation, more than 75 minutes	308	91831	-
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving group of 2 to 9 unrelated patients or a family group of more than 3 patients, each referred to consultant psychiatrist	342	92455	-
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 3 patients, each referred to consultant psychiatrist	344	92456	-
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 2 patients, each referred to consultant psychiatrist	346	92457	
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic evaluation of patient, 20 to 45 minutes	348	92458	-
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic	350	92459	-

evaluation of patient, 45 minutes or more			
Consultant psychiatrist, interview of a person other than patient, in the course of continuing management of patient, not less than 20 minutes, not exceeding 4 attendances per calendar year	352	92460	-
Consultant psychiatrist, prepare an eating disorder treatment and management plan, more than 45 minutes	90260	92162	
Consultant psychiatrist, to review an eating disorder plan, more than 30 minutes	90266	92172	
Paediatrician Services (also refer to consultant physician services)			
Paediatrician, develop a treatment and management plan, patient aged under 25, with a complex neurodevelopmental disorder (such as autism spectrum disorder), at least 45 minutes	135	92140	
Paediatrician, prepare an eating disorder treatment and management plan, more than 45 minutes	90261	92163	
Paediatrician, to review an eating disorder plan, more than 20 minutes	90267	92173	

Public Health Physician Services			
Public health physician, level A attendance	410	92513	92521
Public health physician, level B attendance, less than 20 minutes	411	92514	92522
Public health physician, level C attendance, at least 20 minutes	412	92515	-
Public health physician, level D attendance, at least 40 minutes	413	92516	-
Neurosurgery attendances			
Neurosurgeon, initial attendance	6007	92610	-
Neurosurgeon, minor attendance	6009	92611	92618
Neurosurgeon, subsequent attendance, 15 to 30 minutes	6011	92612	-
Neurosurgeon, subsequent attendance, 30 to 45 minutes	6013	92613	-
Neurosurgeon, subsequent attendance, more than 45 minutes	6015	92614	-
Anaesthetist attendance			
Anaesthetist, professional attendance, advanced or complex	17615	92701	-

Further information on the telehealth changes can be found at www.mbsonline.gov.au by searching under the Facts Sheets tab – July 2022.

Eligible providers

All MBS items for referred attendances require a valid referral. However, if the specialist, consultant physician, consultant psychiatrist, paediatrician or geriatrician has previously seen the patient under a referral that is still valid, there is no need to obtain a specific referral for the purposes of claiming the video and telephone items.

Restrictions

All MBS telehealth and telephone attendance items are stand-alone items and are to be billed instead of a face-to-face MBS item.

Billing Requirements

Bulk billing of specialist (and Allied Health) telehealth services is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Further information on the assignment of benefit for bulk billed MBS telehealth services can be found in the 'Provider Frequently Asked Questions' at www.mbsonline.gov.au.

Relevant definitions and requirements

Specialist telehealth services (91822, 91823 and 91833) can be billed by all specialities that can currently bill items 104 and 105 or equivalent MBS items. This also includes sports and exercise medicine and occupational and environmental health medicine specialists.

Consultant physician telehealth services (91824, 91825, 91826 and 91836) can be billed by all specialities that can currently bill items 110, 116 and 119 or equivalent MBS items. This also includes pain and palliative medicine, sexual health medicine and addiction medicine.

Consultant physician telehealth services to prepare and review a management plan (92422 and 92423) can be billed by all physicians that can currently bill items 132 and 133 or equivalent MBS items. This also includes sexual health medicine, addiction medicine and paediatricians.

The specialist and consultant physician service for diagnosis and treatment for patients with an eligible disability (92141) can be billed by specialists and consultant physicians that are able to item 137.

Single course of treatment

The same conditions for a single course of treatment apply across all modalities (i.e. face-to-face, video or telephone). Once an initial consultation is billed, all subsequent services related to the same condition are considered to be part of a single course of treatment. For example, if a patient has seen a specialist in a face-to-face consultation (where item 104 has been billed), item 91823 (video) or 91833 (telephone) should be billed if the patient sees the specialist remotely for the same condition.

Anaesthetist services

The Anaesthetist telehealth service (92701) can be billed by practitioners that can currently bill item 17615.

Service limits

At present, the service limits that apply to standard psychiatry services do not currently apply to the video and telephone attendance items for psychiatry (except for item 92460). Patients who have received more than 50 attendances under existing items are eligible to receive services under the video and telephone psychiatry items as long as they meet the item descriptor requirements.

In addition, patients who have received more than 50 attendances under item 319 are eligible to receive services under the video and telephone psychiatry items as long as they meet the item descriptor requirements.

The Department of Health and Aged Care will work with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Medicare Review Advisory Committee (MRAC) to review the current service limits, and ensure a consistent approach across all of the psychiatry attendance items, including services provided by face-to-face, video and telephone.

Interview item (92460)

Item 92460 provides for an interview with a person other than the patient. A maximum of 4 services in a calendar year can be billed under item 92460, or the equivalent face-to-face item (item 352), in the continuing management of a patient. That is, a consultant psychiatrist can bill for a service under item 92460 once more in the calendar year if a patient has received three MBS services under items 352 or 92460 in the same calendar year.

Management Plan items (92435 and 92436)

The MBS remote attendance preparation and review of GP management plan items have the same diagnosis, assessment and record-keeping requirements as the existing face-to-face items (291 and 293). Refer to MBS Explanatory Note AN.0.30 for further information.

Group psychotherapy items (92455, 92456 and 92457)

The MBS remote attendance group psychotherapy items have the same requirements as the existing face-to-face items (342, 344 and 346). It is the responsibility of the practitioner rendering the service to maintain privacy and confidentiality for all participants throughout the service. Practitioners should refer to the relevant professional practice standards and guidelines for technology-based consultations.

Technical Requirements

The services can be provided by telehealth and by phone. It is the responsibility of the practitioner rendering the service to maintain privacy and confidentiality for all participants throughout the service.

Telehealth attendance means a professional attendance by video conference where the medical practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains a visual and audio link with the patient; and
d. is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

Note – only the time where a visual and audio link is maintained between the patient and the provider can be counted in meeting the relevant item descriptor.

No specific equipment is required to provide Medicare-compliant telehealth services. Practitioners must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. Information on how to select a web conferencing solution is available at: www.cyber.gov.au

Phone attendance means a professional attendance by telephone where the health practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains an audio link with the patient.

There are no longer geographic restrictions on the MBS video or telephone services provided by specialists, consultant physicians, consultant psychiatrists, paediatricians, geriatricians and anaesthetists.

Recording Clinical Notes (for specialist, consultant physician, consultant psychiatrist, neurosurgery, public health medicine, geriatrician, paediatrician and anaesthetist)

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added later, such as reports of investigations, or when either the visual or audio link between the patient and the practitioner is lost.

Clinicians should record the date, time and duration of the consultation, and retain these records.

AN.40.5 MBS Items for Blood Borne Virus, Sexual and Reproductive Health Services

The video and phone items for the provision of services related to blood borne viruses, sexual or reproductive health provides for Medicare benefits to be paid for these health care services without the requirement for the patient to have an established clinical relationship with the physician. This does not exclude practitioners who have an established clinical relationship with the patient from using these items.

These items are intended to support patient access to medical services where there may be barriers due to privacy or limited service provision, and are not intended to replace routine services that a patient's usual practitioner might provide.

The practitioner must keep adequate and contemporary notes to support the service provided.

There are 24 MBS items for the provision of video or phone services related to blood borne viruses, sexual or reproductive health.

Video consultation

Item 92715 – services provided by a General Practitioner (level A)

Item 92716 – services provided by an Other Medical Practitioner - urban

Item 92717 – services provided by an Other Medical Practitioner – rural

Item 92718 – services provided by a General Practitioner (level B)

Item 92719 – services provided by an Other Medical Practitioner - urban

Item 92720 – services provided by an Other Medical Practitioner – rural

Item 92721 – services provided by a General Practitioner (level C)

Item 92722 – services provided by an Other Medical Practitioner - urban

Item 92723 – services provided by an Other Medical Practitioner – rural

Item 92724 – services provided by a General Practitioner (level D)

Item 92725 – services provided by an Other Medical Practitioner – urban

Item 92726 – services provided by an Other Medical Practitioner – rural

Phone consultation

Item 92731 – services provided by a General Practitioner (level A)

Item 92732 – services provided by an Other Medical Practitioner - urban

Item 92733 – services provided by an Other Medical Practitioner – rural

Item 92734 – services provided by a General Practitioner (level B)

Item 92735 – services provided by an Other Medical Practitioner - urban

Item 92736 – services provided by an Other Medical Practitioner – rural

Item 92737 – services provided by a General Practitioner (level C)

Item 92738 – services provided by an Other Medical Practitioner - urban

Item 92739 – services provided by an Other Medical Practitioner – rural

Item 92740– services provided by a General Practitioner (level D)

Item 92741– services provided by an Other Medical Practitioner – urban

Item 92742 – services provided by an Other Medical Practitioner - rural

To be eligible for use of this item, practitioners must be located at a medical practice or have a formal agreement with a medical practice that provides onsite face to face services to patients.

Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items.

AN.44.1 MBS COVID-19 Vaccine Support Services

MBS COVID-19 Vaccine Support Services

Item descriptions

Attendance items to assess a patient's suitability for a COVID-19 vaccine (items 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656)

Vaccine suitability assessments undertaken by a suitably qualified health professional on behalf of a medical practitioner in a location other than consulting rooms (items 93660 and 93661).

Attendance items for in-depth patient assessment services co-claimed with a vaccine suitability assessment service and provided where additional assessment and advice is required, including in relation to the patient's individual risks and benefits associated with receiving a COVID-19 vaccine (items 10660 and 10661).

Flag-fall item co-claimed with a vaccine suitability assessment service provided as an initial attendance at a residential aged care facility (RACF), residential disability facility setting or a patient's place of residence, on one occasion (item 90005).

All MBS COVID-19 Vaccine Support items must be bulk-billed.

The items can only be billed to Medicare if a dose of a COVID-19 vaccine is available to be given immediately to the patient who is to be assessed. Medical practices that do not have access to supplies of a COVID-19 vaccine for immediate delivery to patients cannot use any of the COVID-19 vaccine items.

In this explanatory note:

Other Medical Practitioner (OMP) includes specialist medical practitioners and consultant physicians working in a general practice setting in their capacity as medical practitioners who are not vocationally registered general practitioners (GPs); and

Suitably qualified health professional refers to a person, including a registered nurse, who is registered in a health profession regulated under the Health Practitioner Regulation National Law. More information is available at the AHPRA website at: www.ahpra.gov.au.

Application of the items

The attendance items for assessing patient suitability for a COVID-19 vaccine may be claimed as follows:

MBS Items 93644, 93645, 93646 and 93647 apply to a professional attendance that:

- is provided in a business hours period for the purpose of assessing a patient's suitability to receive a COVID-19 vaccine; and

- is bulk billed.

MBS Items 93653, 93654, 93655 and 93656 apply to a professional attendance that:

- is provided in an after-hours period hours for the purpose of assessing a patient's suitability to receive a COVID-19 vaccine; and
- is bulk billed.

MBS item 93660 and 93661 applies to a service provided by a suitably qualified health professional on behalf of the GP/OMP out of the consulting rooms and must be bulk billed.

MBS Items 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660 and 93661 can be used to assess vaccine suitability for a patient eligible for any vaccine dose, whether that is part of a primary course or a booster.

MBS items 10660 and 10661 apply to a professional attendance that can only be claimed once per patient during their lifetime. The service is bulk billed and must be personally performed by the medical practitioner.

MBS item 90005 applies only to the first service provided during a single attendance at a RACF, residential disability facility setting or a patient's place of residence. The item is bulk-billed.

Business hours and after-hours services

MBS Items 93644, 93645, 93646, and 93647 apply to a professional attendance that is provided:

- after 8am or before 8pm on a weekday;
- after 8am or before 1.00pm on a Saturday.

MBS Items 93653, 93654, 93655 and 93656 apply to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Geographic requirements

MBS Items 93644, 93646, 93653, 93655 and 93660 apply to a professional attendance delivered in a Modified Monash 1 (metropolitan) location.

MBS Items 93645, 93647, 93654, 93656 and 93661 apply to a professional attendance delivered in a Modified Monash 2-7 (non-metropolitan) location.

A locator map to identify a medical practice's Modified Monash location is available at the Health Workforce Locator website at: www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator.

Eligible practitioners

MBS items 93644, 93645, 93653, 93654 and 10660 relate to attendances rendered by medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by Services Australia; or
- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the ACRRM for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

MBS items 93646, 93647, 93655, 93656 and 10661 relate to attendances rendered by a medical practitioner who is not a general practitioner.

Activities associated with the claiming of MBS items 93644, 93645, 93646, 93647, 93653, 93654, 93655 or 93656 can be undertaken by a GP, OMP or a suitably qualified health professional on the GP/OMP's behalf working within their scope of practice.

Services rendered under MBS items 93644, 93645, 93646, 93647, 93653, 93654, 93655 or 93656 will only attract a Medicare rebate where the service is billed in the name of the supervising GP or OMP, who must be present at the location at which the vaccine suitability assessment service is undertaken and must accept full responsibility for the service.

Services rendered under MBS items 93660 and 93661 may only be claimed by a medical practitioner, who retains clinical responsibility for the service, however, the GP/OMP is not required to be physically present at the location at which the vaccine suitability assessment service is provided. The medical practitioner retains full responsibility for the clinical outcome of the service at all times.

Eligible patients

Services utilising MBS items 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660, 93661, 10660, and 10661 can be provided to any patient who is eligible for Medicare.

Administration of a COVID-19 vaccine

If, following a vaccine suitability assessment service, a patient is offered and agrees to receive a COVID-19 vaccination, the vaccine will be administered (with no other MBS item claimable for that administration). The GP, OMP or suitably qualified health professional responsible for administering the vaccine must be appropriately qualified and trained to provide immunisation to the patient.

Co-administration of a COVID-19 vaccine and an influenza vaccine

ATAGI has advised that a COVID-19 vaccination and an influenza vaccination can be administered at the same time. These services may be provided during the same attendance.

A vaccine suitability assessment MBS item would be billed for the COVID-19 vaccination. Influenza vaccine services are typically administered with standard MBS attendance items.

Note: There are no MBS items for administering an influenza vaccine for and on behalf of a medical practitioner.

While a medical practitioner is under no obligation to bulk-bill a patient receiving an influenza vaccination, a patient who also receives a COVID-19 booster vaccination as part of the same occasion of care must be bulk-billed for the MBS COVID-19 vaccine suitability assessment component of the overall service. Patients should be informed of any potential out of pocket costs before any service is provided, preferably when they book their appointment.

Medical practitioners administering influenza vaccinations should be aware of the requirements of the National Immunisation Program including eligibility criteria for Government funded vaccines.

Billing the COVID-19 vaccine suitability assessment items

The MBS COVID-19 vaccine suitability assessment items can only be billed to Medicare by a GP or OMP.

No additional MBS attendance item can be used to bill Medicare for the time spent administering a vaccine following a suitability assessment service.

Co-claiming the COVID-19 vaccine suitability assessment items with other general attendance items

Patients presenting with multiple clinical matters requiring attention should be encouraged to book a separate consultation, and preferably with their usual medical practice. There may be some circumstances where deferral of treatment is not feasible or in the patient's best interests; these include clinical matters where treatment cannot be deferred or opportunistic treatment for other conditions.

Standard MBS multiple same-day attendance rules apply to the COVID-19 vaccination suitability assessment services. Co-claiming is only permitted where another Medicare service is provided that is unrelated to the vaccine suitability assessment item. Payment of benefit may be made for more than one attendance on a patient on the same day by the same GP or OMP, provided the subsequent attendances are not a continuation of the initial or earlier attendances. Examples of other Medicare services include but are not restricted to: a standard consultation for a different presenting problem; provision of a time-tiered health assessment service; or review of a chronic disease management plan.

Before an additional service is provided to the patient the medical practice must obtain and record the patient's informed financial consent to ensure that they (the patient) understand that there is no cost associated with the vaccine suitability assessment and/or the administration of the vaccine.

Patients must also be informed if any other service that they receive on the same occasion will be bulk-billed or will attract an out of pocket cost.

Note: where a GP or OMP completes a vaccine suitability assessment, but the patient is found to be unsuitable on clinical grounds or declines to receive the vaccination, the service may be billed using the appropriate vaccine suitability assessment item. If the patient returns at a later date, it would be appropriate for another vaccine suitability assessment to be undertaken and a claim made for the relevant Medicare item.

Co-claiming restrictions

The table below lists the restrictions on co-claiming the MBS vaccine support services.

MBS Item(s)	Must be co-claimed	May be co-claimed	Cannot be co-claimed
93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656		90005, 10660, 10661	10990, 10991, 10992, 75855, 75856, 75857, 75858, 10988
93660, 93661		90005	10990, 10991, 10992, 75855, 75856, 75857, 75858,

			10988, 10660, 10661
90005	93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660, 93661	10660, 10661	10990, 10991, 10992, 75855, 75856, 75857, 75858
10660	93644, 93645, 93653, 93654	90005	10990, 10991, 10992, 75855, 75856, 75857, 75858, 93660, 93661
10661	93646, 93647, 93655, 93656	90005	10990, 10991, 10992, 75855, 75856, 75857, 75858, 93660, 93661

Record keeping and reporting requirements

Medical practices participating in the vaccine program need to comply with the record keeping requirements to substantiate a Medicare service.

For the purposes of Medicare, a patient or clinical record should be created or updated at the time a service is provided, or as soon as practicable afterwards. The record needs to:

- clearly identify the name of the patient;
- contain a separate entry for each attendance by the patient for the vaccination suitability assessment service and the date(s) on which the service was provided;
- record the patient's consent to receive the vaccine;
- provide clinical information adequate to explain the service;
- be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care as it relates to COVID-19 vaccinations.

Where a patient receives a service using either MBS item 10660 or 10661 in association with a vaccine suitability assessment service, the reason for the service also needs to be recorded.

Medical practices participating in the Australian Government's COVID-19 vaccination program will be required to update the vaccination status of a patient who has received the vaccine on the Australian Immunisation Register (AIR) portal in line with the Australian Immunisation Register requirements.

Restrictions

MBS items 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660 and 93661 apply only to a professional attendance where:

- the GP, OMP or suitably qualified health professional administering a COVID-19 vaccine is appropriately qualified and trained to provide immunisation to a patient; and
- a dose of COVID-19 vaccine is immediately available for administration to the patient at the practice location.

A service using the items cannot be provided as part of an episode of hospital treatment or hospital-substitute treatment.

AR.8.1 Attendance Services provided under Item 294 are to be provided by video conference rather than at consulting rooms

When a service provided to a patient under item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 is provided under item 294, it may be provided by video conference rather than at consulting rooms.

AR.29.1 Attendance services for eligible disabilities

Eligibility of this service under 137 or 92141 (specialists and consultant physicians), 139 or 92142 (general practitioners)

'Eligible disabilities' for the purpose of these services means any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;

(b) hearing impairment that results in:

(i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

(ii) permanent conductive hearing loss and auditory neuropathy;

(c) deafblindness;

(d) cerebral palsy;

(e) Down syndrome;

(f) Fragile X syndrome;

(g) Prader-Willi syndrome;

(h) Williams syndrome;

(i) Angelman syndrome;

(j) Kabuki syndrome;

(k) Smith-Magenis syndrome;

(l) CHARGE syndrome;

(m) Cri du Chat syndrome;

(n) Cornelia de Lange syndrome;

(o) microcephaly, if a child has:

(i) a head circumference less than the third percentile for age and sex; and

(ii) a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence*;

(p) Rett's disorder;

(q) Fetal Alcohol Spectrum Disorder (FASD);

(r) Lesch-Nyhan syndrome;

(s) 22q deletion syndrome.

*"standard developmental test" refers to tests such as the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner to determine which tests are appropriate to be used.

Information on the Ready Reckoners can be found on the MBS Online downloads page at https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-240701

PROFESSIONAL ATTENDANCES ITEMS

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A1. General Practitioner Attendances To Which No Other Item Applies
Fee 123	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and 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; for one or more health related issues, with appropriate documentation (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $197.90 **Benefit:** 100% = $197.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 124	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 60 minutes and 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; for one or more health related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient (See para AN.0.13, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 123, plus $30.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 123 plus $2.40 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL A
Fee 3	Professional attendance at consulting rooms (other than a service to which another item applies) 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-each attendance (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
Fee 4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 3, plus $30.00 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 $2.40 per patient.

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B
Fee 23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
Fee 24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient (See para AN.0.11, AN.0.13, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 23, plus $30.00 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 $2.40 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C
Fee 36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and 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; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $248.70
Fee 37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and 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; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 36, plus $30.00 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 $2.40 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D
Fee 44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
Fee 47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and 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;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 44, plus $30.00 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 $2.40 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	Group A2. Other Non-Referred Attendances To Which No Other Item Applies
	Subgroup 1. Other Medical Practitioner Attendances
151	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.2.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $98.40 **Benefit:** 100% = $98.40 **Extended Medicare Safety Net Cap:** $295.20
165	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $88.20, 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 $88.20 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT CONSULTING ROOMS
52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category)

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	Fee: $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
57	Professional attendance at consulting rooms lasting more than 45 minutes, but not more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.2.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY
58	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
59	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	more than 25 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 45 minutes but not more than 60 minutes —an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A3. Specialist Attendances To Which No Other Item Applies
Fee 104	Professional attendance at consulting rooms or hospital by a specialist in the practice of the specialist's specialty after referral of the patient to the specialist-each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies (See para TN.1.4, AN.2.1, AN.40.1, AN.0.7, AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $98.95 **Benefit:** 75% = $74.25 85% = $84.15

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $296.85
Fee 105	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies (See para TN.1.4, AN.0.70, AN.2.1, AN.40.1, AN.0.7, AN.3.1, AN.0.25 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies) **Fee:** $82.10 **Benefit:** 75% = $61.60 85% = $69.80 **Extended Medicare Safety Net Cap:** $246.30
Fee 107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital (See para AN.0.25 of explanatory notes to this Category) **Fee:** $145.15 **Benefit:** 75% = $108.90 85% = $123.40 **Extended Medicare Safety Net Cap:** $435.45
Fee 108	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital (See para AN.0.25 of explanatory notes to this Category) **Fee:** $91.90 **Benefit:** 75% = $68.95 85% = $78.15 **Extended Medicare Safety Net Cap:** $275.70
Fee 109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies) (See para AN.0.76 of explanatory notes to this Category) **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55 **Extended Medicare Safety Net Cap:** $500.00
Amend Fee 111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $341.75 or more For any particular patient, once only on the same day **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Amend Fee 115	Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the attending practitioner) who is a specialist or consultant physician in the practice of the attending practitioner's specialty after referral of the patient to the attending practitioner by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if: (a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $341.75 or more; and (d) the attendance is unrelated to the scheduled operation; and (e) it is considered a clinical risk to defer the attendance to a later day For any particular patient, once only on the same day (See para AN.3.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A4. Consultant Physician Attendances To Which No Other Item Applies
Fee 110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.40.1, AN.0.7, AN.0.25 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 119 applies) after the first in a single course of treatment (See para AN.0.70, AN.40.1, AN.0.7, AN.3.1, AN.0.25 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Amend Fee	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
117	consultant physician by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $341.75 or more For any particular patient, once only on the same day **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21, AN.0.70, AN.40.1, AN.0.7, AN.3.1, AN.0.25 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Amend Fee 120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance, if: (a) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the consultant physician subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $341.75 or more For any particular patient, once only on the same day (See para AN.0.21 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.25 of explanatory notes to this Category) **Fee:** $211.65 **Benefit:** 75% = $158.75 85% = $179.95 **Extended Medicare Safety Net Cap:** $500.00

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Fee 128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 131 applies) after the first in a single course of treatment (See para AN.0.25 of explanatory notes to this Category) **Fee:** $128.05 **Benefit:** 75% = $96.05 85% = $108.85 **Extended Medicare Safety Net Cap:** $384.15
Fee 131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21, AN.0.25 of explanatory notes to this Category) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45 **Extended Medicare Safety Net Cap:** $276.75
Fee 132	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician (See para AN.0.23, AN.40.1, AN.0.7 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 133	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers:

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) item 132 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and (f) this item has not applied more than twice in any 12 month period (See para AN.0.23, AN.40.1, AN.0.7 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 75% = $114.60 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A5. Prolonged Attendances To Which No Other Item Applies
	PROLONGED PROFESSIONAL ATTENDANCE
Fee 160	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $252.40 **Benefit:** 75% = $189.30 100% = $252.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 161	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $420.55 **Benefit:** 75% = $315.45 100% = $420.55 **Extended Medicare Safety Net Cap:** $500.00

A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Fee 162	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $588.55 **Benefit:** 75% = $441.45 100% = $588.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 163	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $757.10 **Benefit:** 75% = $567.85 100% = $757.10 **Extended Medicare Safety Net Cap:** $500.00
Fee 164	Professional attendance by a general practitioner, specialist or consultant physician for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $841.20 **Benefit:** 75% = $630.90 100% = $841.20 **Extended Medicare Safety Net Cap:** $500.00

A6. GROUP THERAPY	
	Group A6. Group Therapy
Fee 170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 2 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $133.95 **Benefit:** 75% = $100.50 100% = $133.95 **Extended Medicare Safety Net Cap:** $401.85
Fee 171	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 3 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $141.10 **Benefit:** 75% = $105.85 100% = $141.10 **Extended Medicare Safety Net Cap:** $423.30
Fee 172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 4 or more patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $171.70 **Benefit:** 75% = $128.80 100% = $171.70 **Extended Medicare Safety Net Cap:** $500.00

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 1. Acupuncture
Fee 193	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29 of explanatory notes to this Category) **Fee:** $42.20 **Benefit:** 100% = $42.20 **Extended Medicare Safety Net Cap:** $126.60
Fee 195	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, on one or more patients at a hospital, for treatment lasting less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29 of explanatory notes to this Category) **Derived Fee:** The fee for item 193, plus $29.60 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	1. ACUPUNCTURE
Fee 197	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 20 minutes and 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; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 199	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 100% = $120.25 **Extended Medicare Safety Net Cap:** $360.75

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 2. Prescribed medical practitioner attendance to which no other item applies

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
Fee 179	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance (See para GN.7.17, AN.7.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $15.70 **Benefit:** 100% = $15.70 **Extended Medicare Safety Net Cap:** $47.10
Fee 181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting not more than 5 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 179, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $1.90 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 185	Professional attendance at consulting rooms lasting more than 5 minutes but not more than 25 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance (See para GN.7.17, AN.7.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $34.25 **Benefit:** 100% = $34.25 **Extended Medicare Safety Net Cap:** $102.75
Fee 187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 5 minutes but not more than 25 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 185, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $1.90 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 189	Professional attendance at consulting rooms lasting more than 25 minutes but not more than 45 minutes (other than a service to which any other applies) by a prescribed medical practitioner in an eligible area—each attendance (See para GN.7.17, AN.7.1, AN.7.2, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 25 minutes but not more than 45 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category)

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
	Derived Fee: The fee for item 189, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $1.90 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 203	Professional attendance at consulting rooms lasting more than 45 minutes but not more than 60 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10
Fee 206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 45 minutes but not more than 60 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 203, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 203 plus $1.90 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 301	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item in this Schedule applies) by a prescribed medical practitioner in an eligible area—each attendance (See para AN.7.2, AN.7.1, GN.7.17, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $158.30 **Benefit:** 100% = $158.30 **Extended Medicare Safety Net Cap:** $474.90
Fee 303	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para AN.7.1, AN.7.2, GN.7.17, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 301, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 301 plus $1.90 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. PRESCRIBED MEDICAL PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 3. Prescribed medical practitioner prolonged attendances to which no other item applies

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. PRESCRIBED MEDICAL PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
Fee 214	Professional attendance by a prescribed medical practitioner for a period of not less than one hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $201.95 **Benefit:** 75% = $151.50 100% = $201.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 215	Professional attendance by a prescribed medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $336.50 **Benefit:** 75% = $252.40 100% = $336.50 **Extended Medicare Safety Net Cap:** $500.00
Fee 218	Professional attendance by a prescribed medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $470.80 **Benefit:** 75% = $353.10 100% = $470.80 **Extended Medicare Safety Net Cap:** $500.00
Fee 219	Professional attendance by a prescribed medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $605.70 **Benefit:** 75% = $454.30 100% = $605.70 **Extended Medicare Safety Net Cap:** $500.00
Fee 220	Professional attendance by a prescribed medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $672.95 **Benefit:** 75% = $504.75 100% = $672.95 **Extended Medicare Safety Net Cap:** $500.00

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	4. PRESCRIBED MEDICAL PRACTITIONER GROUP THERAPY
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 4. Prescribed medical practitioner group therapy
Fee 221	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 2 patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $107.10 **Benefit:** 75% = $80.35 100% = $107.10 **Extended Medicare Safety Net Cap:** $321.30
Fee 222	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 3 patients

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	4. PRESCRIBED MEDICAL PRACTITIONER GROUP THERAPY
	(See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $112.90 **Benefit:** 75% = $84.70 100% = $112.90 **Extended Medicare Safety Net Cap:** $338.70
Fee 223	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $137.35 **Benefit:** 75% = $103.05 100% = $137.35 **Extended Medicare Safety Net Cap:** $412.05

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. PRESCRIBED MEDICAL PRACTITIONER HEALTH ASSESSMENTS
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 5. Prescribed medical practitioner health assessments
Amend Fee 177	Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a prescribed medical practitioner at consulting rooms lasting at least 20 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination, which must include recording blood pressure and cholesterol; and (c) initiating interventions and referrals as indicated; and (d) implementing a management plan; and (e) providing the patient with preventative health care advice and information. (See para AN.14.2 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 224	Professional attendance by a prescribed medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.0.36, AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69 of explanatory notes to this Category) **Fee:** $54.10 **Benefit:** 100% = $54.10 **Extended Medicare Safety Net Cap:** $162.30
Fee 225	Professional attendance by a prescribed medical practitioner 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; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.0.36, AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69 of explanatory notes to this Category) **Fee:** $125.70 **Benefit:** 100% = $125.70

	Extended Medicare Safety Net Cap: $377.10
Fee 226	Professional attendance by a prescribed medical practitioner 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; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient (See para AN.0.36, AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69 of explanatory notes to this Category) **Fee:** $173.40 **Benefit:** 100% = $173.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 227	Professional attendance by a prescribed medical practitioner to perform a prolonged health assessment, lasting at least 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions and referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.0.36, AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69 of explanatory notes to this Category) **Fee:** $245.00 **Benefit:** 100% = $245.00 **Extended Medicare Safety Net Cap:** $500.00
Fee 228	Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—applicable not more than once in a 9 month period and only if the following items are not applicable within the same 9 month period: (a) item 715; (b) item 92004 or 92011 of the Telehealth and Telephone Determination (See para AN.7.1, AN.7.13, AN.7.14, AN.7.15, AN.7.16 of explanatory notes to this Category) **Fee:** $193.45 **Benefit:** 100% = $193.45 **Extended Medicare Safety Net Cap:** $500.00

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 6. Prescribed medical practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences
Fee 229	Attendance by a prescribed medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $131.50 **Benefit:** 75% = $98.65 100% = $131.50 **Extended Medicare Safety Net Cap:** $394.50

Fee 230	Attendance by a prescribed medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $104.20 **Benefit:** 75% = $78.15 100% = $104.20 **Extended Medicare Safety Net Cap:** $312.60
Fee 231	Either: (a) contribution to a multidisciplinary care plan, for a patient, prepared by another provider; or (b) contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $64.15 **Benefit:** 75% = $48.15 100% = $64.15 **Extended Medicare Safety Net Cap:** $192.45
Fee 232	Either: (a) contribution to a multidisciplinary care plan, for a patient in a residential aged care facility, prepared by that facility, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a facility; or (b) contribution to a multidisciplinary care plan, for a patient, prepared by another provider before the patient is discharged from a hospital or contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $64.15 **Benefit:** 75% = $48.15 100% = $64.15 **Extended Medicare Safety Net Cap:** $192.45
Fee 233	Attendance by a prescribed medical practitioner: (a) to review a GP management plan prepared by a medical practitioner (or an associated medical practitioner); or (b) to coordinate a review of team care arrangements which have been coordinated by the medical practitioner (or the associated medical practitioner) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $65.65 **Benefit:** 75% = $49.25 100% = $65.65 **Extended Medicare Safety Net Cap:** $196.95
Fee 235	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 100% = $64.50 **Extended Medicare Safety Net Cap:** $193.50
Fee 236	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate:

	(a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $110.25 **Benefit:** 75% = $82.70 100% = $110.25 **Extended Medicare Safety Net Cap:** $330.75
Fee 237	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts at least 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $183.70 **Benefit:** 75% = $137.80 100% = $183.70 **Extended Medicare Safety Net Cap:** $500.00
Fee 238	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $47.35 **Benefit:** 75% = $35.55 100% = $47.35 **Extended Medicare Safety Net Cap:** $142.05
Fee 239	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 75% = $60.90 100% = $81.15 **Extended Medicare Safety Net Cap:** $243.45
Fee 240	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply (See para AN.7.1, AN.7.27 of explanatory notes to this Category)

	Fee: $135.05 **Benefit:** 75% = $101.30 100% = $135.05 **Extended Medicare Safety Net Cap:** $405.15
Fee 243	Attendance by a prescribed medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $63.15 **Benefit:** 75% = $47.40 100% = $63.15 **Extended Medicare Safety Net Cap:** $189.45
Fee 244	Attendance by a prescribed medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $29.45 **Benefit:** 75% = $22.10 100% = $29.45 **Extended Medicare Safety Net Cap:** $88.35
Fee 969	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 100% = $64.50 **Extended Medicare Safety Net Cap:** $193.50
Fee 971	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $110.25 **Benefit:** 75% = $82.70 100% = $110.25 **Extended Medicare Safety Net Cap:** $330.75
Fee 972	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 40 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $183.75 **Benefit:** 75% = $137.85 100% = $183.75 **Extended Medicare Safety Net Cap:** $500.00
Fee 973	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $47.35 **Benefit:** 75% = $35.55 100% = $47.35 **Extended Medicare Safety Net Cap:** $142.05

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	6. PRESCRIBED MEDICAL PRACTITIONER MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
Fee 975	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 75% = $60.90 100% = $81.15 **Extended Medicare Safety Net Cap:** $243.45
Fee 986	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes (See para AN.7.32 of explanatory notes to this Category) **Fee:** $135.05 **Benefit:** 75% = $101.30 100% = $135.05 **Extended Medicare Safety Net Cap:** $405.15

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	7. PRESCRIBED MEDICAL PRACTITIONER DOMICILIARY AND RESIDENTIAL MEDICATION MANAGEMENT REVIEW
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 7. Prescribed medical practitioner domiciliary and residential medication management review
Fee 245	Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the prescribed medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having the patient's therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $141.10 **Benefit:** 100% = $141.10 **Extended Medicare Safety Net Cap:** $423.30
Fee 249	Participation by a prescribed medical practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $96.60 **Benefit:** 100% = $96.60 **Extended Medicare Safety Net Cap:** $289.80

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 9. Prescribed medical practitioner mental health care
Fee 272	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 75% = $49.05 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 276	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $96.20 **Benefit:** 75% = $72.15 100% = $96.20 **Extended Medicare Safety Net Cap:** $288.60
Fee 277	Professional attendance by a prescribed medical practitioner to: (a) review a GP mental health treatment plan which a medical practitioner, or an associated medical practitioner, has prepared; or (b) to review a Psychiatrist Assessment and Management Plan (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 75% = $49.05 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 279	Professional attendance by a prescribed medical practitioner, in relation to a mental disorder, lasting at least 20 minutes and involving: (a) taking relevant history and identifying the presenting problem (to the extent not previously recorded); and (b) providing treatment and advice; and (c) if appropriate, referral for other services or treatments; and (d) documenting the outcomes of the consultation (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 75% = $49.05 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 281	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $82.95 **Benefit:** 75% = $62.25 100% = $82.95 **Extended Medicare Safety Net Cap:** $248.85
Fee 282	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $122.25 **Benefit:** 75% = $91.70 100% = $122.25 **Extended Medicare Safety Net Cap:** $366.75
Fee 283	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:

	(a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 285	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 283, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 283 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 286	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00
Fee 287	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 286, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 286 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 309	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 311	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	9. PRESCRIBED MEDICAL PRACTITIONER MENTAL HEALTH CARE
	the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Derived Fee:** The fee for item 309, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 309 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 313	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00
Fee 315	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Derived Fee:** The fee for item 313, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 313 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	10. PRESCRIBED MEDICAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 10. Prescribed Medical Practitioner after-hours attendances to which no other item applies
Fee 733	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $26.40 **Benefit:** 100% = $26.40 **Extended Medicare Safety Net Cap:** $79.20
Fee 737	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $44.60 **Benefit:** 100% = $44.60 **Extended Medicare Safety Net Cap:** $133.80

Fee 741	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $76.55 **Benefit:** 100% = $76.55 **Extended Medicare Safety Net Cap:** $229.65
Fee 745	Professional attendance at consulting rooms of more than 45 minutes in duration but not more than 60 minutes (other than a service to which another item applies) by a prescribed medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $107.35 **Benefit:** 100% = $107.35 **Extended Medicare Safety Net Cap:** $322.05
Fee 761	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 763	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 766	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 769	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient.

	(See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 772	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a prescribed medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $42.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $3.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 776	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a prescribed medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $42.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $3.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 788	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a prescribed medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $42.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $3.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 789	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes but not more than 60 minutes in duration by a prescribed medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	10. PRESCRIBED MEDICAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	(See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $42.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $3.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 2197	Professional attendance at consulting rooms of more than 60 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner—each attendance. (See para GN.7.17, AN.7.1, AN.7.24, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $182.35 **Benefit:** 100% = $182.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 2198	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 60 minutes—an attendance on one or more patients on one occasion—each patient. (See para AN.7.1, GN.7.17, AN.7.24, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 2197, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2197 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 2200	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 60 minutes in duration by a prescribed medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient. (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 2197, plus $42.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2197 plus $3.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	11. PRESCRIBED MEDICAL PRACTITIONER PREGNANCY SUPPORT COUNSELLING
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 11. Prescribed medical practitioner pregnancy support counselling
Fee 792	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, lasting at least 20 minutes, for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item, or item 4001, 81000, 81005, 81010, 92136, 92137, 92138, 92139, 93026 or 93029, applies in relation to that pregnancy (See para AN.7.25, AN.7.1, MN.8.2 of explanatory notes to this Category)

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	11. PRESCRIBED MEDICAL PRACTITIONER PREGNANCY SUPPORT COUNSELLING
	Fee: $69.80 **Benefit:** 100% = $69.80 **Extended Medicare Safety Net Cap:** $209.40

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A8. Consultant Psychiatrist Attendances To Which No Other Item Applies
Fee 289	Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.40.1, AN.0.72 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 291	Professional attendance lasting more than 45 minutes at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner, for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months that comprehensively evaluates the patient's biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 92435 applies has not been provided to the patient (See para AN.0.30, AN.40.1, AN.0.75, AN.0.76, AN.0.32 of explanatory notes to this Category) **Fee:** $523.40 **Benefit:** 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 293	Professional attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or item 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the revised comprehensive diagnostic assessment of the patient; and

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 or item 92435 applies has been provided to the patient; and (g) in the preceding 12 months, a service to which this item or item 92436 applies has not been provided to the patient (See para AN.0.30, AN.40.1, AN.0.76, AN.0.32 of explanatory notes to this Category) **Fee:** $327.20 **Benefit:** 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 294	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty of psychiatry if: (a) the attendance is by video conference; and (b) except for the requirement for the attendance to be at consulting rooms—item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 would otherwise apply to the attendance; and (c) the patient is not an admitted patient; and (d) the patient is bulk-billed; and (e) the patient: (i) is located: (A) within a Modified Monash 2, 3, 4, 5, 6 or 7 area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal medical service; or (B) an Aboriginal community controlled health service; for which a direction made under subsection 19(2) of the Act applies **Derived Fee:** 50% of the fee for item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319.

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Fee 296	Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at consulting rooms if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (See para AN.0.30, AN.40.1, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $301.05 **Benefit:** 75% = $225.80 85% = $255.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 297	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (H) (See para AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $301.05 **Benefit:** 75% = $225.80 **Extended Medicare Safety Net Cap:** $500.00
Fee 299	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 296, 297, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (See para AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $359.90 **Benefit:** 85% = $305.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category)

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 75% = $115.45 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 75% = $159.30 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient (See para AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $24.95 **Benefit:** 75% = $18.75 85% = $21.25 **Extended Medicare Safety Net Cap:** $74.85

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Fee 312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient (See para AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient (See para AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $77.15 **Benefit:** 75% = $57.90 85% = $65.60 **Extended Medicare Safety Net Cap:** $231.45
Fee 316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient (See para AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40 **Extended Medicare Safety Net Cap:** $318.90
Fee 318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient (See para AN.0.76, AN.0.31, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $123.25 **Benefit:** 75% = $92.45 85% = $104.80 **Extended Medicare Safety Net Cap:** $369.75
Fee 319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes at consulting rooms, if: (a) the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment; and (b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.31, AN.0.76, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 75% = $159.30 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 320	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at hospital (See para AN.0.76, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital (See para AN.0.76, AN.0.32 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital (See para AN.0.76, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 75% = $115.45 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital (See para AN.0.76, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 75% = $159.30 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at hospital (See para AN.0.76, AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital (See para AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $92.00 **Benefit:** 75% = $69.00 85% = $78.20 **Extended Medicare Safety Net Cap:** $276.00
Fee 332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital (See para AN.0.76, AN.0.25 of explanatory notes to this Category)

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $144.05 **Benefit:** 75% = $108.05 85% = $122.45 **Extended Medicare Safety Net Cap:** $432.15
Fee 334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital (See para AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $209.95 **Benefit:** 75% = $157.50 85% = $178.50 **Extended Medicare Safety Net Cap:** $500.00
Fee 336	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital (See para AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $254.05 **Benefit:** 75% = $190.55 85% = $215.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital (See para AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $288.55 **Benefit:** 75% = $216.45 85% = $245.30 **Extended Medicare Safety Net Cap:** $500.00
Fee 341	An interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5, AN.40.1, AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45 **Extended Medicare Safety Net Cap:** $171.00

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Fee 343	An interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5, AN.40.1, AN.0.76, AN.0.25 of explanatory notes to this Category) **Fee:** $75.65 **Benefit:** 75% = $56.75 85% = $64.35 **Extended Medicare Safety Net Cap:** $226.95
Fee 345	An interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 75% = $115.45 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5, AN.40.1, AN.0.76, AN.0.77, AN.0.25 of explanatory notes to this Category) **Fee:** $111.95 **Benefit:** 75% = $84.00 85% = $95.20 **Extended Medicare Safety Net Cap:** $335.85
Fee 347	An interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of:

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 75% = $159.30 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 349	An interview, lasting more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 347, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 **Extended Medicare Safety Net Cap:** $500.00

A9. CONTACT LENSES - ATTENDANCES	
	Group A9. Contact Lenses - Attendances
Fee 10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60

A9. CONTACT LENSES - ATTENDANCES	
	Extended Medicare Safety Net Cap: $422.10
Fee 10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity-whether congenital, traumatic or surgical in origin (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient who, because of physical deformity, are unable to wear spectacles (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account (See para AN.0.34 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10
Fee 10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other

A9. CONTACT LENSES - ATTENDANCES	
	than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply (See para AN.0.35 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Extended Medicare Safety Net Cap:** $422.10

A10. OPTOMETRICAL SERVICES	1. GENERAL
	Group A10. Optometrical Services
	Subgroup 1. General
Fee 10905	REFERRED COMPREHENSIVE INITIAL CONSULTATION Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para AN.10.1 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00
Fee 10907	COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: (a) for a patient who is less than 65 years of age-within the previous 36 months; or (b) for a patient who is at least 65 years or age-within the previous 12 months (See para AN.10.1 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10910	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS LESS THAN 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.10.1 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00

	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS AT LEAST 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.10.1 of explanatory notes to this Category)
Fee 10911	**Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00
	OTHER COMPREHENSIVE CONSULTATIONS Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.10.1 of explanatory notes to this Category)
Fee 10912	**Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00
	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.10.1 of explanatory notes to this Category)
Fee 10913	**Fee:** $76.00 **Benefit:** 85% = $64.60

	Extended Medicare Safety Net Cap: $228.00
Fee 10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied (See para AN.10.1 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00
Fee 10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para AN.10.1 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00
Fee 10916	BRIEF INITIAL CONSULTATION Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10918	SUBSEQUENT CONSULTATION Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10921	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS

	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for

	- patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.2 of explanatory notes to this Category) **Fee:** $238.35 **Benefit:** 85% = $202.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10925	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: i. pathological mydriasis; or ii. aniridia; or

	iii. coloboma of the iris; or iv. pupillary malformation or distortion; or v. significant ocular deformity or corneal opacity -whether congenital, traumatic or surgical in origin (See para AN.0.2 of explanatory notes to this Category) **Fee:** $238.35 **Benefit:** 85% = $202.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who, because of physical deformity, are unable to wear spectacles (See para AN.0.2 of explanatory notes to this Category) **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account *Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O6 of explanatory notes to this category.* (See para AN.0.2 of explanatory notes to this Category) **Fee:** $238.35 **Benefit:** 85% = $202.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by item 10921 to 10929 **Fee:** $188.90 **Benefit:** 85% = $160.60 **Extended Medicare Safety Net Cap:** $500.00

	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on one patient at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.10.1 of explanatory notes to this Category)
Fee 10931	**Fee:** $26.55 **Benefit:** 85% = $22.60 **Extended Medicare Safety Net Cap:** $79.65
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on two patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both:
Fee 10932	

	- this item; and - the applicable item (See para AN.10.1 of explanatory notes to this Category) **Fee:** $13.25 **Benefit:** 85% = $11.30 **Extended Medicare Safety Net Cap:** $39.75
Fee 10933	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on three patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.10.1 of explanatory notes to this Category) **Fee:** $8.75 **Benefit:** 85% = $7.45 **Extended Medicare Safety Net Cap:** $26.25
Fee 10940	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold), with bilateral assessment and report, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multi channel objective perimetry; and (b) is performed by an optometrist; not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies To a maximum of 2 examinations per patient (including examinations to which item 10941 applies) in any 12 month period. (See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $72.55 **Benefit:** 85% = $61.70 **Extended Medicare Safety Net Cap:** $217.65
Fee 10941	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) with unilateral assessment and report, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; not being a service associated with a service to which item 10916, 10918 10931, 10932 or 10933 applies

A10. OPTOMETRICAL SERVICES	1. GENERAL
	To a maximum of 2 examinations per patient (including examinations to which item 10940 applies) in any 12 month period. (See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $43.80 **Benefit:** 85% = $37.25 **Extended Medicare Safety Net Cap:** $131.40
Fee 10942	LOW VISION ASSESSMENT Testing of residual vision to provide optimum visual performance for a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye or a horizontal visual field of less than 120 degrees and within 10 degrees above and below the horizontal midline, involving 1 or more of the following: (a) spectacle correction; (b) determination of contrast sensitivity; (c) determination of glare sensitivity; (d) prescription of magnification aids; not being a service associated with a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies Not payable more than twice per patient in a 12 month period. (See para AN.10.1 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10943	CHILDREN'S VISION ASSESSMENT Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, in a patient aged 3 to 14 years, including assessment of 1 or more of the following: (a) accommodation; (b) ocular motility; (c) vergences; (d) fusional reserves; (e) cycloplegic refraction; not being a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies Not to be used for the assessment of learning difficulties or learning disabilities. Not payable more than once per patient in a 12 month period. (See para AN.10.1 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10944	CORNEA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) The item is not to be billed on the same occasion as MBS items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body is not completely removed, this item does not apply but item 10916 may apply. **Fee:** $82.20 **Benefit:** 85% = $69.90 **Extended Medicare Safety Net Cap:** $246.60

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	Group A10. Optometrical Services
	Subgroup 2. Telehealth Attendance

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
Fee 10945	A professional attendance of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient (See para AN.0.22, MN.12.5 of explanatory notes to this Category) **Fee:** $38.10 **Benefit:** 85% = $32.40 **Extended Medicare Safety Net Cap:** $114.30
Fee 10946	A professional attendance of at least 15 minutes (whether or not continuous) by an optometrist providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in the speciality of ophthalmology; and (b) is not an admitted patient (See para AN.0.22, MN.12.5 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 85% = $64.60 **Extended Medicare Safety Net Cap:** $228.00

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	Group A11. Urgent Attendance After Hours
	Subgroup 1. Urgent Attendance - After Hours
Fee 585	Professional attendance by a general practitioner on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $147.90 **Benefit:** 75% = $110.95 100% = $147.90 **Extended Medicare Safety Net Cap:** $443.70
Fee 588	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	(c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $147.90 **Benefit:** 75% = $110.95 100% = $147.90 **Extended Medicare Safety Net Cap:** $443.70
Fee 591	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $102.55 **Benefit:** 75% = $76.95 100% = $102.55 **Extended Medicare Safety Net Cap:** $307.65
Fee 594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient (See para AN.0.19 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 75% = $35.85 100% = $47.80 **Extended Medicare Safety Net Cap:** $143.40

A11. URGENT ATTENDANCE AFTER HOURS	2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
	Group A11. Urgent Attendance After Hours
	Subgroup 2. Urgent Attendance Unsociable After Hours
Fee 599	Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $174.30 **Benefit:** 75% = $130.75 100% = $174.30 **Extended Medicare Safety Net Cap:** $500.00
Fee 600	Professional attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion—each attendance in unsociable hours if:

A11. URGENT ATTENDANCE AFTER HOURS	2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
	(a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $139.30 **Benefit:** 75% = $104.50 100% = $139.30 **Extended Medicare Safety Net Cap:** $417.90

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A12. Consultant Occupational Physician Attendances To Which No Other Item Applies
Fee 385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $98.95 **Benefit:** 75% = $74.25 85% = $84.15 **Extended Medicare Safety Net Cap:** $296.85
Fee 386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $145.15 **Benefit:** 75% = $108.90 85% = $123.40 **Extended Medicare Safety Net Cap:** $435.45
Fee 388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $91.90 **Benefit:** 75% = $68.95 85% = $78.15 **Extended Medicare Safety Net Cap:** $275.70

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A13. Public Health Physician Attendances To Which No Other Item Applies
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS
Fee 410	LEVEL A Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine 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 AN.0.50, AN.40.1 of explanatory notes to this Category) **Fee:** $22.60 **Benefit:** 75% = $16.95 85% = $19.25 **Extended Medicare Safety Net Cap:** $67.80
Fee 411	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms 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. (See para AN.0.50, AN.40.1 of explanatory notes to this Category) **Fee:** $49.40 **Benefit:** 75% = $37.05 85% = $42.00 **Extended Medicare Safety Net Cap:** $148.20
Fee 412	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms 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. (See para AN.0.50, AN.40.1 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 75% = $71.75 85% = $81.35

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $286.95
Fee 413	LEVEL D Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms 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. (See para AN.0.50, AN.40.1 of explanatory notes to this Category) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70 **Extended Medicare Safety Net Cap:** $422.40
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS
Fee 414	LEVEL A Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms 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 AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 410, plus $29.50 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 415	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms, 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. (See para AN.0.50 of explanatory notes to this Category)

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Derived Fee: The fee for item 411, plus $29.50 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 416	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms 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. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 412, plus $29.50 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 417	LEVEL D Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 413, plus $29.50 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A14. HEALTH ASSESSMENTS	
	Group A14. Health Assessments

A14. HEALTH ASSESSMENTS	
	HEALTH ASSESSMENTS
Fee 699	Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a general practitioner at consulting rooms lasting at least 20 minutes and including: a. collection of relevant information, including taking a patient history; and b. a basic physical examination, which must include recording blood pressure and cholesterol; and c. initiating interventions and referrals as indicated; and d. implementing a management plan; and e. providing the patient with preventative health care advice and information. (See para AN.14.2 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
Fee 701	Professional attendance by a general practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $67.60 **Benefit:** 100% = $67.60 **Extended Medicare Safety Net Cap:** $202.80
Fee 703	Professional attendance by a general practitioner 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; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $157.10 **Benefit:** 100% = $157.10 **Extended Medicare Safety Net Cap:** $471.30

A14. HEALTH ASSESSMENTS	
Fee 705	Professional attendance by a general practitioner 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; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $216.80 **Benefit:** 100% = $216.80 **Extended Medicare Safety Net Cap:** $500.00
Fee 707	Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $306.25 **Benefit:** 100% = $306.25 **Extended Medicare Safety Net Cap:** $500.00
	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT
Fee 715	Professional attendance by a general practitioner 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 AN.0.44, AN.0.46, AN.0.43, AN.0.45 of explanatory notes to this Category) **Fee:** $241.85 **Benefit:** 100% = $241.85 **Extended Medicare Safety Net Cap:** $500.00

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	1. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 1. GP Management Plans, Team Care Arrangements And Multidisciplinary Care Plans
Fee 721	Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $164.35 **Benefit:** 75% = $123.30 100% = $164.35 **Extended Medicare Safety Net Cap:** $493.05

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	1. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
Fee 723	Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $130.25 **Benefit:** 75% = $97.70 100% = $130.25 **Extended Medicare Safety Net Cap:** $390.75
Fee 729	Contribution by a general practitioner to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $80.20 **Benefit:** 100% = $80.20 **Extended Medicare Safety Net Cap:** $240.60
Fee 731	Contribution by a general practitioner to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $80.20 **Benefit:** 100% = $80.20 **Extended Medicare Safety Net Cap:** $240.60
Fee 732	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies (See para AN.0.47 of explanatory notes to this Category) **Fee:** $82.10 **Benefit:** 75% = $61.60 100% = $82.10 **Extended Medicare Safety Net Cap:** $246.30

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 2. Case Conferences
Fee 735	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or

	(c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $80.55 **Benefit:** 75% = $60.45 100% = $80.55 **Extended Medicare Safety Net Cap:** $241.65
Fee 739	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $137.75 **Benefit:** 75% = $103.35 100% = $137.75 **Extended Medicare Safety Net Cap:** $413.25
Fee 743	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $229.65 **Benefit:** 75% = $172.25 100% = $229.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 747	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $59.20 **Benefit:** 75% = $44.40 100% = $59.20 **Extended Medicare Safety Net Cap:** $177.60

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
Fee 750	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $101.45 **Benefit:** 75% = $76.10 100% = $101.45 **Extended Medicare Safety Net Cap:** $304.35
Fee 758	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) **Fee:** $168.80 **Benefit:** 75% = $126.60 100% = $168.80 **Extended Medicare Safety Net Cap:** $500.00
Fee 820	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 822	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 823	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
Fee 825	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 826	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 828	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00
Fee 830	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 832	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 834	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 835	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and

	coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 837	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 838	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00
Fee 855	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 857	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 858	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 861	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category)

	Fee: $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 864	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 866	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 871	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category) **Fee:** $92.85 **Benefit:** 75% = $69.65 85% = $78.95 **Extended Medicare Safety Net Cap:** $278.55
Fee 872	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category) **Fee:** $43.25 **Benefit:** 75% = $32.45 85% = $36.80 **Extended Medicare Safety Net Cap:** $129.75
Fee 880	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes-for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H) (See para AN.0.63 of explanatory notes to this Category) **Fee:** $56.25 **Benefit:** 75% = $42.20 **Extended Medicare Safety Net Cap:** $168.75
Fee 930	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $80.55 **Benefit:** 75% = $60.45 100% = $80.55 **Extended Medicare Safety Net Cap:** $241.65

Fee 933	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $137.75 **Benefit:** 75% = $103.35 100% = $137.75 **Extended Medicare Safety Net Cap:** $413.25
Fee 935	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 40 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $229.65 **Benefit:** 75% = $172.25 100% = $229.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 937	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $59.20 **Benefit:** 75% = $44.40 100% = $59.20 **Extended Medicare Safety Net Cap:** $177.60
Fee 943	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $101.45 **Benefit:** 75% = $76.10 100% = $101.45 **Extended Medicare Safety Net Cap:** $304.35
Fee 945	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 40 minutes (See para AN.15.1 of explanatory notes to this Category) **Fee:** $168.80 **Benefit:** 75% = $126.60 100% = $168.80 **Extended Medicare Safety Net Cap:** $500.00
Fee 946	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 948	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 959	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
	coordinate a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 961	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 962	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 964	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.15.2 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Group A17. Domiciliary And Residential Management Reviews
Fee 900	Participation by a general practitioner (not including a specialist or consultant physician) in a Domiciliary Medication Management Review (***DMMR***) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.0.52 of explanatory notes to this Category)

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Fee: $176.40 **Benefit:** 100% = $176.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 903	Participation by a general practitioner (not including a specialist or consultant physician) in a residential medication management review (***RMMR***) for a patient who is a care recipient in a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 249 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR. (See para AN.0.52 of explanatory notes to this Category) **Fee:** $120.80 **Benefit:** 100% = $120.80 **Extended Medicare Safety Net Cap:** $362.40

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
	Group A20. GP Mental Health Treatment
	Subgroup 1. GP Mental Health Treatment Plans
Fee 2700	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 75% = $61.30 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 2701	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 75% = $90.20 100% = $120.25 **Extended Medicare Safety Net Cap:** $360.75
Fee 2712	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 75% = $61.30 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 2713	Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 2715	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $103.70 **Benefit:** 75% = $77.80 100% = $103.70 **Extended Medicare Safety Net Cap:** $311.10

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
Fee 2717	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 75% = $114.60 100% = $152.80 **Extended Medicare Safety Net Cap:** $458.40

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	Group A20. GP Mental Health Treatment
	Subgroup 2. Focussed Psychological Strategies
Fee 2721	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 2723	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2721, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 2725	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 2727	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2725, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 2739	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	(a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes, but less than 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 2741	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes, but less than 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 2739, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2739 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 2743	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 2745	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 2743, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2743 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
	Group A21. Professional Attendances at Recognised Emergency Departments of Private Hospitals

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
	Subgroup 1. Consultations
Fee 5001	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $66.85 **Benefit:** 75% = $50.15 85% = $56.85 **Extended Medicare Safety Net Cap:** $200.55
Fee 5004	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $112.25 **Benefit:** 75% = $84.20 85% = $95.45 **Extended Medicare Safety Net Cap:** $336.75
Fee 5011	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $112.25 **Benefit:** 75% = $84.20 85% = $95.45 **Extended Medicare Safety Net Cap:** $336.75
Fee 5012	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high (See para AN.0.60 of explanatory notes to this Category) **Fee:** $175.95 **Benefit:** 75% = $132.00 85% = $149.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 5013	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high (See para AN.0.60 of explanatory notes to this Category) **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 5014	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high (See para AN.0.60 of explanatory notes to this Category) **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 5016	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45

	Extended Medicare Safety Net Cap: $500.00
Fee 5017	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $342.50 **Benefit:** 75% = $256.90 85% = $291.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 5019	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $342.50 **Benefit:** 75% = $256.90 85% = $291.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 5021	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 5022	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $84.20 **Benefit:** 75% = $63.15 85% = $71.60 **Extended Medicare Safety Net Cap:** $252.60
Fee 5027	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $84.20 **Benefit:** 75% = $63.15 85% = $71.60 **Extended Medicare Safety Net Cap:** $252.60
Fee 5030	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high (See para AN.0.60 of explanatory notes to this Category) **Fee:** $131.90 **Benefit:** 75% = $98.95 85% = $112.15 **Extended Medicare Safety Net Cap:** $395.70
Fee 5031	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
	(See para AN.0.60 of explanatory notes to this Category) **Fee:** $166.00 **Benefit:** 75% = $124.50 85% = $141.10 **Extended Medicare Safety Net Cap:** $498.00
Fee 5032	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high (See para AN.0.60 of explanatory notes to this Category) **Fee:** $166.00 **Benefit:** 75% = $124.50 85% = $141.10 **Extended Medicare Safety Net Cap:** $498.00
Fee 5033	Professional attendance, on a patient 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $222.75 **Benefit:** 75% = $167.10 85% = $189.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 5035	Professional attendance, on a patient aged under 4 years, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $256.90 **Benefit:** 75% = $192.70 85% = $218.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 5036	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity (See para AN.0.60 of explanatory notes to this Category) **Fee:** $256.90 **Benefit:** 75% = $192.70 85% = $218.40 **Extended Medicare Safety Net Cap:** $500.00

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	Group A21. Professional Attendances at Recognised Emergency Departments of Private Hospitals
	Subgroup 2. Prolonged Professional Attendances To Which No Other Group Applies
Fee 5039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (See para AN.0.61 of explanatory notes to this Category) **Fee:** $162.30 **Benefit:** 75% = $121.75 85% = $138.00

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	Extended Medicare Safety Net Cap: $486.90
Fee 5041	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (d) the attendance is for at least 60 minutes (See para AN.0.61 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 5042	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (See para AN.0.61 of explanatory notes to this Category) **Fee:** $121.80 **Benefit:** 75% = $91.35 85% = $103.55 **Extended Medicare Safety Net Cap:** $365.40
Fee 5044	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (d) the attendance is for at least 60 minutes (See para AN.0.61 of explanatory notes to this Category) **Fee:** $228.85 **Benefit:** 75% = $171.65 85% = $194.55 **Extended Medicare Safety Net Cap:** $500.00

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A22. General Practitioner After-Hours Attendances To Which No Other Item Applies
Fee 5071	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation (See para AN.0.9, AN.0.19, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $227.95 **Benefit:** 100% = $227.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 5076	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 60 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient (See para AN.0.11, AN.0.9, AN.0.19, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5071, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5071 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 5077	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 60 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.19, AN.0.9, AN.0.15, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5071, plus $53.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5071 plus $3.80 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL A
Fee 5000	Professional attendance at consulting rooms (other than a service to which another item applies) 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-each attendance (See para AN.0.19, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $33.00 **Benefit:** 100% = $33.00

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $99.00
Fee 5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $29.60 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) 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-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $53.25 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 $3.80 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B
Fee 5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation (See para AN.0.19, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $55.80 **Benefit:** 100% = $55.80 **Extended Medicare Safety Net Cap:** $167.40
Fee 5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $29.60 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 5028	Professional attendance by a general practitioner (other than a service to which another item in this Schedule applies), on care recipients in a residential aged care facility, lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $53.25 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 $3.80 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C
Fee 5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and 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; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $95.70 **Benefit:** 100% = $95.70 **Extended Medicare Safety Net Cap:** $287.10
Fee 5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and 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;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $29.60 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 5049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and 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; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $53.25 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 $3.80 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D
Fee 5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category)

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $134.20 **Benefit:** 100% = $134.20 **Extended Medicare Safety Net Cap:** $402.60
Fee 5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $29.60 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 $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 5067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $53.25 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 $3.80 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A23. Other Non-Referred After-Hours Attendances To Which No Other Item Applies

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
5209	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner) (See para MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $122.40 **Benefit:** 100% = $122.40 **Extended Medicare Safety Net Cap:** $367.20
5261	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting more than 60 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $112.20, 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 $112.20 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5262	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient at the facility and is not a resident of a self-contained unit, lasting more than 60 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $112.20, 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 $112.20 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT CONSULTING ROOMS
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance (See para MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $31.00 **Benefit:** 100% = $31.00 **Extended Medicare Safety Net Cap:** $93.00

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance (See para MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $48.00 **Benefit:** 100% = $48.00 **Extended Medicare Safety Net Cap:** $144.00
5208	Professional attendance at consulting rooms lasting more than 45 minutes, but not more than 60 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner) (See para MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $71.00 **Benefit:** 100% = $71.00 **Extended Medicare Safety Net Cap:** $213.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	another item in this Schedule applies), lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 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 $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY
5260	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5267	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but not more than 60 minutes, by a

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 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 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 1. Pain Medicine Attendances
Fee 2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.65 **Benefit:** 85% = $179.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	attendance (other than a service to which item 2840 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $128.05 **Benefit:** 85% = $108.85 **Extended Medicare Safety Net Cap:** $384.15
Fee 2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $92.25 **Benefit:** 85% = $78.45 **Extended Medicare Safety Net Cap:** $276.75

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 2. Pain Medicine Case Conferences
Fee 2946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 2949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 2954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 2958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes

	(See para AN.0.58 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 2974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00
Fee 2978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 2984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 2988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 2992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 2996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 3000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 3. Palliative Medicine Attendances
Fee 3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.65 **Benefit:** 85% = $179.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $128.05 **Benefit:** 85% = $108.85 **Extended Medicare Safety Net Cap:** $384.15

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
Fee 3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $92.25 **Benefit:** 85% = $78.45 **Extended Medicare Safety Net Cap:** $276.75

A24. PAIN AND PALLIATIVE MEDICINE	4. PALLIATIVE MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 4. Palliative Medicine Case Conferences
Fee 3032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 3040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 3044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 3051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 3055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.58 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 3062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to

	participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00
Fee 3069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70 **Extended Medicare Safety Net Cap:** $482.40
Fee 3074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $241.35 **Benefit:** 75% = $181.05 85% = $205.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 3078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $321.55 **Benefit:** 75% = $241.20 85% = $273.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 3083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20 **Extended Medicare Safety Net Cap:** $346.50
Fee 3088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 75% = $138.20 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00
Fee 3093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05 **Extended Medicare Safety Net Cap:** $500.00

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A26. Neurosurgery Attendances To Which No Other Item Applies
Fee 6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital (See para AN.0.64, AN.40.1 of explanatory notes to this Category) **Fee:** $149.80 **Benefit:** 75% = $112.35 85% = $127.35 **Extended Medicare Safety Net Cap:** $449.40
Fee 6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-a minor attendance after the first in a single course of treatment at consulting rooms or hospital (See para AN.0.64, AN.40.1, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital (See para AN.0.64, AN.40.1, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $98.95 **Benefit:** 75% = $74.25 85% = $84.15 **Extended Medicare Safety Net Cap:** $296.85
Fee 6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64, AN.40.1, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $137.05 **Benefit:** 75% = $102.80 85% = $116.50 **Extended Medicare Safety Net Cap:** $411.15
Fee 6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64, AN.40.1, AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00

A27. PREGNANCY SUPPORT COUNSELLING	
	Group A27. Pregnancy Support Counselling
Fee 4001	Professional attendance of at least 20 minutes in duration at consulting rooms by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a patient who: (a) is currently pregnant; or

A27. PREGNANCY SUPPORT COUNSELLING	
	(b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act. (See para AN.0.66, MN.8.2 of explanatory notes to this Category) **Fee:** $87.25 **Benefit:** 100% = $87.25 **Extended Medicare Safety Net Cap:** $261.75

A28. GERIATRIC MEDICINE	
	Group A28. Geriatric Medicine
Fee 141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months (See para AN.0.26, AN.40.1 of explanatory notes to this Category) **Fee:** $523.40 **Benefit:** 75% = $392.55 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00

A28. GERIATRIC MEDICINE	
	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26, AN.40.1 of explanatory notes to this Category)
Fee 143	**Fee:** $327.20 **Benefit:** 75% = $245.40 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00
	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and
Fee 145	

A28. GERIATRIC MEDICINE	
	(C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months (See para AN.0.26 of explanatory notes to this Category) **Fee:** $634.60 **Benefit:** 85% = $539.45 **Extended Medicare Safety Net Cap:** $500.00
Fee 147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26 of explanatory notes to this Category) **Fee:** $396.70 **Benefit:** 85% = $337.20 **Extended Medicare Safety Net Cap:** $500.00

A29. ATTENDANCE SERVICES FOR COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY	
	Group A29. Attendance services for complex neurodevelopmental disorder or disability

A29. ATTENDANCE SERVICES FOR COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY	
Fee 135	Professional attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.0.24, AN.40.1 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 137	Professional attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to:

A29. ATTENDANCE SERVICES FOR COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY	
	(i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.0.25, AN.40.1, AR.29.1 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 139	Professional attendance lasting at least 45 minutes, at a place other than a hospital, by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AR.29.1, AN.0.73 of explanatory notes to this Category) **Fee:** $153.25 **Benefit:** 100% = $153.25 **Extended Medicare Safety Net Cap:** $459.75

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	Group A31. Addiction Medicine
	Subgroup 1. Addiction Medicine Attendances
Fee 6018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and

	(b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 6019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment (See para AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 6023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 6024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period **Fee:** $152.80 **Benefit:** 75% = $114.60 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A31. ADDICTION MEDICINE	2. GROUP THERAPY
	Group A31. Addiction Medicine
	Subgroup 2. Group Therapy
Fee 6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner-for each patient **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45 **Extended Medicare Safety Net Cap:** $171.00

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	Group A31. Addiction Medicine
	Subgroup 3. Addiction Medicine Case Conferences
Fee 6029	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $49.35 **Benefit:** 75% = $37.05 85% = $41.95

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	Extended Medicare Safety Net Cap: $148.05
Fee 6031	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 6032	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40 **Extended Medicare Safety Net Cap:** $393.15
Fee 6034	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 6035	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $39.50 **Benefit:** 75% = $29.65 85% = $33.60 **Extended Medicare Safety Net Cap:** $118.50
Fee 6037	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $69.85 **Benefit:** 75% = $52.40 85% = $59.40 **Extended Medicare Safety Net Cap:** $209.55
Fee 6038	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $104.80 **Benefit:** 75% = $78.60 85% = $89.10 **Extended Medicare Safety Net Cap:** $314.40
Fee 6042	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $139.55 **Benefit:** 75% = $104.70 85% = $118.65 **Extended Medicare Safety Net Cap:** $418.65

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	Group A32. Sexual Health Medicine
	Subgroup 1. Sexual Health Medicine Attendances
Fee 6051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 6052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment (See para AN.0.70, AN.3.1 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 6057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions;

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	(iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist **Fee:** $305.15 **Benefit:** 75% = $228.90 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 6058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period **Fee:** $152.80 **Benefit:** 75% = $114.60 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A32. SEXUAL HEALTH MEDICINE	2. HOME VISITS
	Group A32. Sexual Health Medicine
	Subgroup 2. Home Visits
Fee 6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the

A32. SEXUAL HEALTH MEDICINE	2. HOME VISITS
	patient to the sexual health medicine specialist by a referring practitioner-initial attendance in a single course of treatment **Fee:** $211.65 **Benefit:** 85% = $179.95 **Extended Medicare Safety Net Cap:** $500.00
Fee 6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-each attendance after the attendance under item 6062 in a single course of treatment **Fee:** $128.05 **Benefit:** 85% = $108.85 **Extended Medicare Safety Net Cap:** $384.15

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	Group A32. Sexual Health Medicine
	Subgroup 3. Sexual Health Medicine Case Conferences
Fee 6064	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $49.35 **Benefit:** 75% = $37.05 85% = $41.95 **Extended Medicare Safety Net Cap:** $148.05
Fee 6065	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 6067	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40 **Extended Medicare Safety Net Cap:** $393.15
Fee 6068	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 75% = $130.90 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 6071	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $39.50 **Benefit:** 75% = $29.65 85% = $33.60 **Extended Medicare Safety Net Cap:** $118.50
Fee 6072	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $69.85 **Benefit:** 75% = $52.40 85% = $59.40 **Extended Medicare Safety Net Cap:** $209.55
Fee 6074	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $104.80 **Benefit:** 75% = $78.60 85% = $89.10 **Extended Medicare Safety Net Cap:** $314.40
Fee 6075	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $139.55 **Benefit:** 75% = $104.70 85% = $118.65 **Extended Medicare Safety Net Cap:** $418.65

A33. TRANSCATHETER AORTIC VALVE IMPLANTATION AND TRANSCATHETER MITRAL VALVE REPLACEMENT CASE CONFERENCE.	
	Group A33. Transcatheter Aortic Valve Implantation and Transcatheter Mitral Valve Replacement Case Conference.
Fee 6080	Coordination of a TAVI Case Conference by a TAVI Practitioner where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than once per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $58.00 **Benefit:** 75% = $43.50 85% = $49.30 **Extended Medicare Safety Net Cap:** $174.00
Fee 6081	Attendance at a TAVI Case Conference by a specialist or consultant physician who does not also perform the service described in item 6080 for the same case conference where the TAVI Case Conference has a duration of 10 minutes or more.

A33. TRANSCATHETER AORTIC VALVE IMPLANTATION AND TRANSCATHETER MITRAL VALVE REPLACEMENT CASE CONFERENCE.	
	(Not payable more than twice per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $43.25 **Benefit:** 75% = $32.45 85% = $36.80 **Extended Medicare Safety Net Cap:** $129.75
Fee 6082	Attendance at a TMVr suitability case conference, by a cardiothoracic surgeon or an interventional cardiologist, to coordinate the conference, if: (a) the attendance lasts at least 10 minutes; and (b) the surgeon or cardiologist is accredited by the TMVr accreditation committee to perform the service Applicable once each 5 years **Fee:** $58.00 **Benefit:** 75% = $43.50 85% = $49.30 **Extended Medicare Safety Net Cap:** $174.00
Fee 6084	Attendance at a TMVr suitability case conference, by a specialist or consultant physician, other than to coordinate the conference, if the attendance lasts at least 10 minutes Applicable once each 5 years **Fee:** $43.25 **Benefit:** 75% = $32.45 85% = $36.80 **Extended Medicare Safety Net Cap:** $129.75

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	1. FLAG FALL AMOUNT FOR RESIDENTIAL AGED CARE FACILITIES
	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 1. Flag Fall Amount For Residential Aged Care Facilities
Amend Fee 90001	For the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90020, 90035, 90043, 90051 or 90054 applies is the amount listed in the item plus $62.65. (See para AN.35.1 of explanatory notes to this Category) **Fee:** $62.65 **Benefit:** 100% = $62.65 **Extended Medicare Safety Net Cap:** $187.95
Amend Fee 90002	For the first patient attended during one attendance by a medical practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90092, 90093, 90095, 90096, 90098, 90183, 90188, 90202, 90212 or 90215 applies is the amount listed in the item plus $45.50. (See para AN.35.2 of explanatory notes to this Category) **Fee:** $45.50 **Benefit:** 100% = $45.50 **Extended Medicare Safety Net Cap:** $136.50
Fee 90005	A flag fall service to which item 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660 or 93661 applies. For the first patient attended during one attendance by a general practitioner or by a medical practitioner (other than a general practitioner) at: (a) one residential aged care facility, or at consulting rooms situated within such a complex, on one occasion; or

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	1. FLAG FALL AMOUNT FOR RESIDENTIAL AGED CARE FACILITIES
	(b) one residential disability setting facility, or at consulting rooms situated within such a complex, on one occasion; or (c) a person's place of residence (other than a residential aged care facility) on one occasion. (See para AN.44.1 of explanatory notes to this Category) **Fee:** $149.75 **Benefit:** 85% = $127.30

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 2. General Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Fee 90020	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) 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—an attendance on one or more patients at one residential aged care facility on one occasion - each patient. (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
Fee 90035	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 6 minutes and less than 20 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1) (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
Fee 90043	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and 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;

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
Fee 90051	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
Fee 90054	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 60 minutes and 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; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1) (See para AN.35.1, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $197.90 **Benefit:** 100% = $197.90 **Extended Medicare Safety Net Cap:** $500.00

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	3. OTHER MEDICAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 3. Other Medical Practitioner Non-Referred Attendance At A Residential Aged Care Facility

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	3. OTHER MEDICAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
90092	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $8.50 **Benefit:** 100% = $8.50 **Extended Medicare Safety Net Cap:** $25.50
90093	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $16.00 **Benefit:** 100% = $16.00 **Extended Medicare Safety Net Cap:** $48.00
90095	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 100% = $35.50 **Extended Medicare Safety Net Cap:** $106.50
90096	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but less than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $57.50 **Benefit:** 100% = $57.50 **Extended Medicare Safety Net Cap:** $172.50
90098	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a medical practitioner who is not a general practitioner—each patient (subject to subclause 2.30.1(2)) (See para AN.7.2, AN.7.1, AN.35.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category)

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	3. OTHER MEDICAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Fee: $88.20 **Benefit:** 100% = $88.20 **Extended Medicare Safety Net Cap:** $264.60

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	4. NON-SPECIALIST PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 4. Non-Specialist Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Fee 90183	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting not more than 5 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $15.70 **Benefit:** 100% = $15.70 **Extended Medicare Safety Net Cap:** $47.10
Fee 90188	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 5 minutes but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $34.25 **Benefit:** 100% = $34.25 **Extended Medicare Safety Net Cap:** $102.75
Fee 90202	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 25 minutes but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 90212	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes but not more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category)

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	4. NON-SPECIALIST PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Fee: $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10
Fee 90215	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.2, AN.7.1, AN.35.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $158.30 **Benefit:** 100% = $158.30 **Extended Medicare Safety Net Cap:** $474.90

A36. EATING DISORDER SERVICES	1. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: GENERAL PRACTITIONERS AND NON SPECIALIST MEDICAL PRACTITIONERS
	Group A36. Eating Disorder Services
	Subgroup 1. Preparation of eating disorder treatment and management plans: general practitioners and non specialist medical practitioners
Fee 90250	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 90251	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 100% = $120.25 **Extended Medicare Safety Net Cap:** $360.75
Fee 90252	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $103.70 **Benefit:** 100% = $103.70 **Extended Medicare Safety Net Cap:** $311.10
Fee 90253	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 100% = $152.80 **Extended Medicare Safety Net Cap:** $458.40

A36. EATING DISORDER SERVICES	1. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: GENERAL PRACTITIONERS AND NON SPECIALIST MEDICAL PRACTITIONERS
Fee 90254	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plant, lasting at least 20 minutes but less than 40 minutes. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 90255	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $96.20 **Benefit:** 100% = $96.20 **Extended Medicare Safety Net Cap:** $288.60
Fee 90256	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $82.95 **Benefit:** 100% = $82.95 **Extended Medicare Safety Net Cap:** $248.85
Fee 90257	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $122.25 **Benefit:** 100% = $122.25 **Extended Medicare Safety Net Cap:** $366.75

A36. EATING DISORDER SERVICES	2. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: CONSULTANT PHYSICIANS
	Group A36. Eating Disorder Services
	Subgroup 2. Preparation of eating disorder treatment and management plans: consultant physicians
Fee 90260	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes (See para AN.36.1, AN.36.2, AN.40.1 of explanatory notes to this Category) **Fee:** $523.40 **Benefit:** 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 90261	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to prepare an eating disorder treatment and management plan, if:

A36. EATING DISORDER SERVICES	2. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: CONSULTANT PHYSICIANS
	(a) the patient is referred; and (b) the attendance lasts at least 45 minutes (See para AN.36.1, AN.36.2, AN.40.1 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00

A36. EATING DISORDER SERVICES	3. REVIEW OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Group A36. Eating Disorder Services
	Subgroup 3. Review of eating disorder treatment and management plans
Fee 90264	Professional attendance by a general practitioner to review an eating disorder treatment and management plan. (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 90265	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to review an eating disorder treatment and management plan. (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 90266	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 30 minutes (See para AN.36.1, AN.36.3, AN.40.1 of explanatory notes to this Category) **Fee:** $327.20 **Benefit:** 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 90267	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 20 minutes (See para AN.36.1, AN.36.3, AN.40.1 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A36. EATING DISORDER SERVICES	4. PROVIDING TREATMENTS UNDER EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Group A36. Eating Disorder Services

A36. EATING DISORDER SERVICES	4. PROVIDING TREATMENTS UNDER EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Subgroup 4. Providing treatments under eating disorder treatment and management plans
Fee 90271	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 90272	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 90271, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90271 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 90273	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 90274	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** Derived Fee: The fee for item 90273, plus $29.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90273 plus $2.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 90275	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 90276	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** Derived Fee: The fee for item 90275, plus $23.65 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90275 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 90277	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00

A36. EATING DISORDER SERVICES	4. PROVIDING TREATMENTS UNDER EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Extended Medicare Safety Net Cap: $363.00
Fee 90278	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** Derived Fee: The fee for item 90277, plus $23.65 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90277 plus $1.85 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A37. CARDIOTHORACIC SURGEON ATTENDANCE FOR LEAD EXTRACTION	
	Group A37. Cardiothoracic Surgeon Attendance for Lead Extraction
Fee 90300	Professional attendance by a cardiothoracic surgeon in the practice of the surgeon's speciality, if: (a) the service is: (i) performed in conjunction with a service (the lead extraction service) to which item 38358 applies; or (ii) performed in conjunction with a service (the leadless pacemaker extraction service) to which item 38373 or 38374 applies; and (b) the surgeon: (i) is providing surgical backup for the provider (who is not a cardiothoracic surgeon) who is performing the lead extraction service or the leadless pacemaker extraction service; and (ii) is present for the duration of the lead extraction service or the leadless pacemaker extraction service, other than during the low risk pre and post extraction phases; and (iii) is able to immediately scrub in and perform a thoracotomy if major complications occur (H) (See para TN.8.214 of explanatory notes to this Category) **Fee:** $980.15 **Benefit:** 75% = $735.15

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	1. GENERAL PRACTICE TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 1. General practice telehealth services
Fee 91790	Telehealth 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 management.

	NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
91792	Telehealth attendance by a medical practitioner of not more than 5 minutes. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
Fee 91794	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 minutes NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $15.70 **Benefit:** 100% = $15.70 **Extended Medicare Safety Net Cap:** $47.10
Fee 91800	Telehealth attendance by a general practitioner lasting at least 6 minutes but less than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care

	(See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
Fee 91801	Telehealth attendance by a general practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
Fee 91802	Telehealth attendance by a general practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
91803	Telehealth attendance by a medical practitioner of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan;

	(d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
91804	Telehealth attendance by a medical practitioner of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
91805	Telehealth attendance by a medical practitioner (not including a general practitioner) of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).

	(See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
Fee 91806	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $34.25 **Benefit:** 100% = $34.25 **Extended Medicare Safety Net Cap:** $102.75
Fee 91807	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05

	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5 of explanatory notes to this Category)
Fee 91808	**Fee:** $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10
	Telehealth attendance by a general practitioner, lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5, MN.1.6 of explanatory notes to this Category)
Fee 91920	**Fee:** $197.90 **Benefit:** 100% = $197.90 **Extended Medicare Safety Net Cap:** $500.00
	Telehealth attendance by a medical practitioner (not including a general practitioner), of more than 60 minutes in duration and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category)
91923	**Fee:** $98.40 **Benefit:** 100% = $98.40 **Extended Medicare Safety Net Cap:** $295.20

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	1. GENERAL PRACTICE TELEHEALTH SERVICES
	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 60 minutes in duration and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). (See para MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5 of explanatory notes to this Category)
Fee 91926	**Fee:** $158.30 **Benefit:** 100% = $158.30 **Extended Medicare Safety Net Cap:** $474.90

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	2. GENERAL PRACTICE PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 2. General practice phone services
	Phone attendance by a general practitioner lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category)
Fee 91890	**Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
	Phone attendance by a general practitioner lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category)
Fee 91891	**Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category)
91892	**Fee:** $11.00 **Benefit:** 100% = $11.00

	Extended Medicare Safety Net Cap: $33.00
91893	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
Fee 91900	Phone attendance by a general practitioner to a patient registered under MyMedicare with the billing practice, lasting at least 20 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; for one or more health related issues, with appropriate documentation (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
91903	Phone attendance by a medical practitioner (not including a general practitioner) to a patient registered under MyMedicare with the billing practice, of more than 25 minutes in duration but not more than 45 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; for one or more health related issues, with appropriate documentation (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
Fee 91906	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, to a patient registered under MyMedicare with the billing practice, of more than 25 minutes in duration but not more than 45 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history;

	(b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 91910	Phone attendance by a general practitioner, to a patient registered under MyMedicare with the billing practice, lasting at least 40 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation (See para MN.1.7, AN.0.74, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
91913	Phone attendance by a medical practitioner (not including a general practitioner), to a patient registered under MyMedicare with the billing practice, of more than 45 minutes in duration but not more than 60 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; for one or more health related issues, with appropriate documentation (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
Fee 91916	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, to a patient registered under MyMedicare with the billing practice, of more than 45 minutes in duration but not more than 60 minutes, if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; for one or more health related issues, with appropriate documentation (See para MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10

	Group A40. Telehealth and phone attendance services
	Subgroup 3. Focussed Psychological Strategies telehealth services
Fee 91818	Telehealth attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 91819	Telehealth attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 91820	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes (See para AN.7.23 of explanatory notes to this Category) **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 91821	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and

	(b) the service lasts at least 40 minutes (See para AN.7.23 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00
Fee 91859	Telehealth attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 91861	Telehealth attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 91862	Telehealth attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $84.50 **Benefit:** 100% = $84.50 **Extended Medicare Safety Net Cap:** $253.50
Fee 91863	Telehealth attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	4. SPECIALIST ATTENDANCES TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 4. Specialist attendances telehealth services
Fee 91822	Telehealth attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance was other than a second or subsequent attendance as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.0.25 of explanatory notes to this Category) **Fee:** $98.95 **Benefit:** 85% = $84.15 **Extended Medicare Safety Net Cap:** $296.85
Fee 91823	Telehealth attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	5. CONSULTANT PHYSICIAN TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 5. Consultant physician telehealth services
Fee 91824	Telehealth attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance was other than a second or subsequent attendance as part of a single course of treatment.

	(See para AN.40.1, AN.0.7 of explanatory notes to this Category) **Fee:** $174.50 **Benefit:** 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00
Fee 91825	Telehealth attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is not a minor attendance after the first as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $87.30 **Benefit:** 85% = $74.25 **Extended Medicare Safety Net Cap:** $261.90
Fee 91826	Telehealth attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is a minor attendance after the first as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
Fee 92422	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves:

	(i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119 of the general medical services table or item 91824, 91825, 91826 or 91836 applies did not take place on the same day by the same consultant physician; and (d) this item, or item 132 of the general medical services table, has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician (See para AN.40.1, AN.0.7 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 92423	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119 of the general medical services table or 91824, 91825, 91826 or 91836 applies did not take place on the same day by the same consultant physician; and (d) item 132 of the general medical services table or item 92422 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 of the general medical services table or 92422; and (f) this item, or item 133 of the general medical services table has not applied more than twice in any 12 month period

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	5. CONSULTANT PHYSICIAN TELEHEALTH SERVICES
	(See para AN.40.1, AN.0.7 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	6. CONSULTANT PSYCHIATRIST TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 6. Consultant psychiatrist telehealth services
Fee 91827	Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91828 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year (See para AN.0.30, AN.0.75, AN.0.31 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91828	Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; if that attendance and another attendance to which item 296, 297, 299, or any of items 300, 302, 304, 306 to 308, 91827, 91829 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year **Fee:** $100.00 **Benefit:** 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 91829	Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827, 91828, 91830, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year **Fee:** $153.90 **Benefit:** 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 91830	Telehealth attendance for a person by a consultant psychiatrist; if:

	(a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 45 minutes, but not more than 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91829, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year **Fee:** $212.40 **Benefit:** 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 91831	Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91830, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year. (See para AN.0.30, AN.0.75, AN.0.31, AN.0.25 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 85% = $209.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 91868	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91869, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient **Fee:** $24.95 **Benefit:** 85% = $21.25 **Extended Medicare Safety Net Cap:** $74.85
Fee 91869	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient **Fee:** $50.10 **Benefit:** 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91870	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient

	Fee: $77.15 **Benefit:** 85% = $65.60 **Extended Medicare Safety Net Cap:** $231.45
Fee 91871	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 45 minutes but not more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient **Fee:** $106.30 **Benefit:** 85% = $90.40 **Extended Medicare Safety Net Cap:** $318.90
Fee 91872	Telehealth attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91873, or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient **Fee:** $123.25 **Benefit:** 85% = $104.80 **Extended Medicare Safety Net Cap:** $369.75
Fee 91873	Telehealth attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the psychiatrist by a referring practitioner, where the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment, if that attendance and another attendance to which any of items 296, 297, 299 or any of items 300, 302, 304, 306, 308, 319, 92437, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91872 or 91879 to 91881 applies has not exceeded 160 attendances in a calendar year for the patient (See para AN.0.31 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 91874	Telehealth attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91875, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category)

	Fee: $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91875	Telehealth attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 91876	Telehealth attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 75% = $115.45 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 91877	Telehealth attendance involving an interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $212.40 **Benefit:** 75% = $159.30 85% = $180.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 91878	Telehealth attendance involving an interview, lasting more than 75 minutes, of a person other than the patient, when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or

	(b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876, 91877, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 **Extended Medicare Safety Net Cap:** $500.00
Fee 92434	Telehealth attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 289, 92140, 92141 or 92142) Applicable only once per lifetime (See para AN.0.72 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 92435	Telehealth attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and

	(iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant and (d) within 2 weeks after the attendance, the consultant prepares and gives the referring practitioner a written report, which includes: (i) a comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months for the patient that comprehensively evaluates the patient's biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and a gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 291 of the general medical services table applies has not been provided (See para AN.0.30, AN.0.75, AN.0.76 of explanatory notes to this Category) **Fee:** $523.40 **Benefit:** 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 92436	Telehealth attendance lasting more than 30 minutes, but not more than 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) a revised comprehensive diagnostic assessment of the patient; and

	(ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and the management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 of the general medical services table or item 92435 applies has been provided; and (g) in the preceding 12 months, a service to which this item or item 293 of the general medical services table applies has not been provided (See para AN.0.30 of explanatory notes to this Category) **Fee:** $327.20 **Benefit:** 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00
Fee 92437	Telehealth attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner: (a) if the patient: (i) is a new patient for this consultant physician; or (ii) has not received an attendance from this consultant physician in the preceding 24 months; and (b) the patient has not received an attendance under this item, or item 91827 to 91831, 91837 to 91839, 92455 to 92457, 91868 to 91873, 91879 to 91881 or item 296, 297, 299, 300, 302, 304, 306 to 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344 or 346 of the general medical services table, in the preceding 24 months (See para AN.0.30, AN.0.75, AN.0.76, AN.0.31, AN.0.25 of explanatory notes to this Category) **Fee:** $301.05 **Benefit:** 85% = $255.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 92455	Telehealth attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner; —each patient (See para AN.0.25 of explanatory notes to this Category) **Fee:** $57.00 **Benefit:** 85% = $48.45 **Extended Medicare Safety Net Cap:** $171.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	6. CONSULTANT PSYCHIATRIST TELEHEALTH SERVICES
Fee 92456	Telehealth attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner; —each patient **Fee:** $75.65 **Benefit:** 85% = $64.35 **Extended Medicare Safety Net Cap:** $226.95
Fee 92457	Telehealth attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner; —each patient **Fee:** $111.95 **Benefit:** 85% = $95.20 **Extended Medicare Safety Net Cap:** $335.85

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	7. SPECIALIST ATTENDANCES PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 7. Specialist attendances phone services
Fee 91833	Phone attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.3.1, AN.0.70, AN.0.25 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	8. CONSULTANT PHYSICIAN PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 8. Consultant physician phone services
Fee 91836	Phone attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is a minor attendance after the first as part of a single course of treatment. (See para AN.40.1, AN.0.7, AN.3.1, AN.0.70, AN.0.25 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	9. CONSULTANT PSYCHIATRIST PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 9. Consultant psychiatrist phone services
Fee 91837	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91838, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year (See para AN.0.30, AN.0.75, AN.0.31 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91838	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year **Fee:** $100.00 **Benefit:** 85% = $85.00

	Extended Medicare Safety Net Cap: $300.00
Fee 91839	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91838 and 92437 applies have not exceeded 50 attendances in a calendar year (See para AN.0.30, AN.0.75, AN.0.31, AN.0.25 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70
Fee 91879	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91880, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient **Fee:** $24.95 **Benefit:** 85% = $21.25 **Extended Medicare Safety Net Cap:** $74.85
Fee 91880	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient **Fee:** $50.10 **Benefit:** 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91881	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91880 or 92437 applies exceed 50 attendances in a calendar year for the patient **Fee:** $77.15 **Benefit:** 85% = $65.60 **Extended Medicare Safety Net Cap:** $231.45
Fee 91882	Phone attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	9. CONSULTANT PSYCHIATRIST PHONE SERVICES
	(b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $50.10 **Benefit:** 75% = $37.60 85% = $42.60 **Extended Medicare Safety Net Cap:** $150.30
Fee 91883	Phone attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91884 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $300.00
Fee 91884	Phone attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91883 applies have not exceeded 15 in a calendar year for the patient (See para AN.0.32 of explanatory notes to this Category) **Fee:** $153.90 **Benefit:** 75% = $115.45 85% = $130.85 **Extended Medicare Safety Net Cap:** $461.70

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	10. FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 10. Focussed Psychological Strategies phone services
Fee 91842	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and

	(b) the service lasts at least 30 minutes, but less than 40 minutes. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 91843	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 91844	Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes (See para AN.7.23 of explanatory notes to this Category) **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 91845	Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes (See para AN.7.23 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00
Fee 91864	Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	10. FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
Fee 91865	Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.20.1 of explanatory notes to this Category) **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 91866	Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $84.50 **Benefit:** 100% = $84.50 **Extended Medicare Safety Net Cap:** $253.50
Fee 91867	Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes (See para AN.7.31 of explanatory notes to this Category) **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	11. HEALTH ASSESSMENT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 11. Health Assessment for Aboriginal and Torres Strait Islander People – Telehealth Service
Fee 92004	Telehealth attendance by a general practitioner for a health assessment of a patient - this item or items 93470 or 93479 not more than once in a 9 month period. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $241.85 **Benefit:** 100% = $241.85 **Extended Medicare Safety Net Cap:** $500.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	11. HEALTH ASSESSMENT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE – TELEHEALTH SERVICE
	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for a health assessment - this item or items 93470 or 93479 not more than once in a 9 month period. NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).
Fee 92011	**Fee:** $193.45 **Benefit:** 100% = $193.45 **Extended Medicare Safety Net Cap:** $500.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	13. CHRONIC DISEASE MANAGEMENT (CDM) SERVICE – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 13. Chronic Disease Management (CDM) Service – Telehealth Service
	Telehealth attendance by a general practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).
Fee 92024	**Fee:** $164.35 **Benefit:** 100% = $164.35 **Extended Medicare Safety Net Cap:** $493.05
	Telehealth attendance by a general practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).
Fee 92025	**Fee:** $130.25 **Benefit:** 100% = $130.25 **Extended Medicare Safety Net Cap:** $390.75
	Contribution by a general practitioner by telehealth, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).
Fee 92026	**Fee:** $80.20 **Benefit:** 100% = $80.20 **Extended Medicare Safety Net Cap:** $240.60

Fee 92027	Contribution by a general practitioner by telehealth to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider. (other than a service associated with a service to which items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $80.20 **Benefit:** 100% = $80.20 **Extended Medicare Safety Net Cap:** $240.60
Fee 92028	Telehealth attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which items 229 or 721 of the general medical services table, or item 92024, 92055, 92068 or 92099 applies; (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which items 230 or 723 of the general medical services table, or item 92025 or 92069 applies NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $82.10 **Benefit:** 100% = $82.10 **Extended Medicare Safety Net Cap:** $246.30
Fee 92055	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $131.50 **Benefit:** 100% = $131.50 **Extended Medicare Safety Net Cap:** $394.50
Fee 92056	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply).

	Fee: $104.20 **Benefit:** 100% = $104.20 **Extended Medicare Safety Net Cap:** $312.60
Fee 92057	Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by telehealth to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $64.15 **Benefit:** 100% = $64.15 **Extended Medicare Safety Net Cap:** $192.45
Fee 92058	Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by telehealth to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $64.15 **Benefit:** 100% = $64.15 **Extended Medicare Safety Net Cap:** $192.45
Fee 92059	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 721 or item 229 of the general medical services table or item 92024, 92055, 92068 or 92099 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which items 230 or 723 of the general medical services table or item 92025, 92056, 92069 or 92100 applies NOTE: It is a legislative requirement that this service must be performed by the patient's usual medical practitioner (please see Note AN.1.1 for the definition of 'patient's usual medical practitioner' as some exemptions do apply). **Fee:** $65.65 **Benefit:** 100% = $65.65 **Extended Medicare Safety Net Cap:** $196.95

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	15. GP PREGNANCY SUPPORT COUNSELLING – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 15. GP Pregnancy Support Counselling – Telehealth Service
Fee 92136	Telehealth attendance of at least 20 minutes in duration by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010 of the Allied Health Determination, or item 92137, 92138, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2 of explanatory notes to this Category) **Fee:** $87.25 **Benefit:** 100% = $87.25 **Extended Medicare Safety Net Cap:** $261.75
Fee 92137	Telehealth attendance of at least 20 minutes in duration by a medical practitioner (not including a general practitioner, specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010 of the Allied Health Determination, or item 92136, 92138, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2 of explanatory notes to this Category) **Fee:** $69.80 **Benefit:** 100% = $69.80 **Extended Medicare Safety Net Cap:** $209.40

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	16. GP PREGNANCY SUPPORT COUNSELLING – PHONE SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 16. GP Pregnancy Support Counselling – Phone Service
Fee 92138	Phone attendance of at least 20 minutes in duration by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010 of the Allied Health Determination, or item 92136, 92137, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2 of explanatory notes to this Category) **Fee:** $87.25 **Benefit:** 100% = $87.25 **Extended Medicare Safety Net Cap:** $261.75
Fee 92139	Phone attendance of at least 20 minutes in duration by a medical practitioner (not including a general practitioner, specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	16. GP PREGNANCY SUPPORT COUNSELLING – PHONE SERVICE
	(b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010 of the Allied Health Determination or item 92136, 92137, 92138, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2 of explanatory notes to this Category) **Fee:** $69.80 **Benefit:** 100% = $69.80 **Extended Medicare Safety Net Cap:** $209.40

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	17. GP, SPECIALIST AND CONSULTANT PHYSICIAN COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY SERVICE - TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 17. GP, specialist and consultant physician complex neurodevelopmental disorder or disability service - telehealth service
Fee 92140	Telehealth attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 289, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.0.24 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00

Fee 92141	Telehealth attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 289, 92140, 92142 or 92434) Applicable only once per lifetime (See para AR.29.1, AN.0.25 of explanatory notes to this Category) **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00
Fee 92142	Telehealth attendance lasting at least 45 minutes by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient;

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	17. GP, SPECIALIST AND CONSULTANT PHYSICIAN COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY SERVICE - TELEHEALTH SERVICE
	(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 289, 92140, 92141 or 92434) Applicable only once per lifetime (See para AR.29.1, AN.0.73 of explanatory notes to this Category) **Fee:** $153.25 **Benefit:** 100% = $153.25 **Extended Medicare Safety Net Cap:** $459.75

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	19. GP MENTAL HEALTH TREATMENT PLAN – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 19. GP Mental Health Treatment Plan – Telehealth Service
Fee 92112	Telehealth attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92113	Telehealth attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 100% = $120.25 **Extended Medicare Safety Net Cap:** $360.75
Fee 92114	Telehealth attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92115	Telehealth attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10

Fee 92116	Telehealth attendance, by a general practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $103.70 **Benefit:** 100% = $103.70 **Extended Medicare Safety Net Cap:** $311.10
Fee 92117	Telehealth attendance, by a general practitioner who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $152.80 **Benefit:** 100% = $152.80 **Extended Medicare Safety Net Cap:** $458.40
Fee 92118	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92119	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22 of explanatory notes to this Category) **Fee:** $96.20 **Benefit:** 100% = $96.20 **Extended Medicare Safety Net Cap:** $288.60
Fee 92120	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (See para AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92121	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92122	Telehealth attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22 of explanatory notes to this Category) **Fee:** $82.95 **Benefit:** 100% = $82.95 **Extended Medicare Safety Net Cap:** $248.85

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	19. GP MENTAL HEALTH TREATMENT PLAN – TELEHEALTH SERVICE
Fee 92123	Telehealth attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22 of explanatory notes to this Category) **Fee:** $122.25 **Benefit:** 100% = $122.25 **Extended Medicare Safety Net Cap:** $366.75

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	20. GP MENTAL HEALTH TREATMENT PLAN – PHONE SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 20. GP Mental Health Treatment Plan – Phone Service
Fee 92126	Phone attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92127	Phone attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation. (See para AN.0.56 of explanatory notes to this Category) **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92132	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (See para AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92133	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.7.22 of explanatory notes to this Category) **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	21. GP EATING DISORDER TREATMENT AND MANAGEMENT PLAN – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 21. GP Eating Disorder Treatment and Management Plan – Telehealth Service

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	21. GP EATING DISORDER TREATMENT AND MANAGEMENT PLAN – TELEHEALTH SERVICE
Fee 92146	Telehealth attendance by a general practitioner who has not undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92147	Telehealth attendance by a general practitioner who has not undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $120.25 **Benefit:** 100% = $120.25 **Extended Medicare Safety Net Cap:** $360.75
Fee 92148	Telehealth attendance by a general practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and

	(d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $103.70 **Benefit:** 100% = $103.70 **Extended Medicare Safety Net Cap:** $311.10
Fee 92149	Telehealth attendance by a general practitioner who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $152.80 **Benefit:** 100% = $152.80 **Extended Medicare Safety Net Cap:** $458.40
Fee 92150	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) who has not undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92151	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) who has not undertaken mental health skills training, of at least 40 minutes in

	duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder **Fee:** $96.20 **Benefit:** 100% = $96.20 **Extended Medicare Safety Net Cap:** $288.60
Fee 92152	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder **Fee:** $82.95 **Benefit:** 100% = $82.95 **Extended Medicare Safety Net Cap:** $248.85
Fee 92153	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	21. GP EATING DISORDER TREATMENT AND MANAGEMENT PLAN – TELEHEALTH SERVICE
	(d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder **Fee:** $122.25 **Benefit:** 100% = $122.25 **Extended Medicare Safety Net Cap:** $366.75

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	23. CONSULTANT PHYSICIAN AND PSYCHIATRIST - EATING DISORDER TREATMENT AND MANAGEMENT PLAN – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 23. Consultant Physician and Psychiatrist - Eating Disorder Treatment and Management Plan – Telehealth Service
Fee 92162	Telehealth attendance of at least 45 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of psychiatry for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to:

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	23. CONSULTANT PHYSICIAN AND PSYCHIATRIST - EATING DISORDER TREATMENT AND MANAGEMENT PLAN – TELEHEALTH SERVICE
	(A) the patient; and (B) the patient's carer (if any), if the patient agrees. **Fee:** $523.40 **Benefit:** 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 92163	Telehealth attendance of at least 45 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of paediatrics for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant paediatrician undertakes an assessment that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of diagnoses; and (c) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that involves: (A) an opinion on diagnosis and risk assessment; and (B) treatment options and decisions; and (C) medication recommendations; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees. **Fee:** $305.15 **Benefit:** 85% = $259.40 **Extended Medicare Safety Net Cap:** $500.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN - TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN - TELEHEALTH SERVICE
	Subgroup 25. Review of an Eating Disorder Plan - Telehealth Service
Fee 92170	Telehealth attendance by a general practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the general practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the general practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92171	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to review an eligible patient's eating disorder treatment and management plan prepared by the medical practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the speciality of psychiatry or paediatrics, if: (a) the medical practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the speciality of psychiatry or paediatrics, where appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and

	(ii) suitable education about the eating disorder **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05
Fee 92172	Telehealth attendance of at least 30 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of psychiatry for an eligible patient, if: (a) the consultant psychiatrist reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees. **Fee:** $327.20 **Benefit:** 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00
Amend Fee 92173	Telehealth attendance of at least 20 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of paediatrics for an eligible patient, if: (a) the consultant paediatrician reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant paediatrician:

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN - TELEHEALTH SERVICE
	(i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees **Fee:** $152.80 **Benefit:** 85% = $129.90 **Extended Medicare Safety Net Cap:** $458.40

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	26. REVIEW OF AN EATING DISORDER PLAN – PHONE SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 26. Review of an Eating Disorder Plan – Phone Service
Fee 92176	Phone attendance by a general practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the general practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the general practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees):

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	26. REVIEW OF AN EATING DISORDER PLAN – PHONE SERVICE
	(i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10
Fee 92177	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) to review an eligible patient's eating disorder treatment and management plan prepared by the medical practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the medical practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $65.35 **Benefit:** 100% = $65.35 **Extended Medicare Safety Net Cap:** $196.05

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	27. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 27. GP - Eating Disorder Focussed Psychological Strategies – Telehealth Service
Fee 92182	Telehealth attendance by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 92184	Telehealth attendance by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	27. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – TELEHEALTH SERVICE
	an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 92186	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 92188	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	28. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – PHONE SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 28. GP - Eating Disorder Focussed Psychological Strategies – Phone Service
Fee 92194	Phone attendance by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. **Fee:** $105.65 **Benefit:** 100% = $105.65 **Extended Medicare Safety Net Cap:** $316.95
Fee 92196	Phone attendance by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. **Fee:** $151.20 **Benefit:** 100% = $151.20 **Extended Medicare Safety Net Cap:** $453.60
Fee 92198	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	28. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – PHONE SERVICE
	of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan **Fee:** $84.55 **Benefit:** 100% = $84.55 **Extended Medicare Safety Net Cap:** $253.65
Fee 92200	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. **Fee:** $121.00 **Benefit:** 100% = $121.00 **Extended Medicare Safety Net Cap:** $363.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	29. GP AND OTHER MEDICAL PRACTITIONER – URGENT AFTER HOURS SERVICE IN UNSOCIABLE HOURS – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 29. GP and Other Medical Practitioner – Urgent After Hours Service in Unsociable Hours – Telehealth Service
Fee 92210	Telehealth attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment. (See para AN.1.1 of explanatory notes to this Category) **Fee:** $174.30 **Benefit:** 100% = $174.30 **Extended Medicare Safety Net Cap:** $500.00
Fee 92211	Telehealth attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment. (See para AN.1.1 of explanatory notes to this Category) **Fee:** $139.30 **Benefit:** 100% = $139.30 **Extended Medicare Safety Net Cap:** $417.90

	Group A40. Telehealth and phone attendance services
	Subgroup 31. Geriatric Medicine Telehealth Service
Fee 92623	Telehealth attendance of more than 60 minutes in duration by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) all relevant aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116, 119 of the general medical services table or item, 91822, 91823, 91833, 91824, 91825, 91826 or 91836 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 of the general medical services table applies has not been provided to the patient by the same practitioner in the preceding 12 months **Fee:** $523.40 **Benefit:** 85% = $444.90 **Extended Medicare Safety Net Cap:** $500.00
Fee 92624	Telehealth attendance of more than 30 minutes in duration by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a

	management plan previously prepared by that consultant physician or specialist under item 141, 92623 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141, 92623 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116, 119 of the general medical services table or item 91822, 91823, 91833, 91824, 91825, 91826 or 91836 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 of the general medical services table or item 92623 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item, or item 147 of the general medical services table applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review **Fee:** $327.20 **Benefit:** 85% = $278.15 **Extended Medicare Safety Net Cap:** $500.00

	Group A40. Telehealth and phone attendance services
	Subgroup 33. Public health physician – Telehealth Services
Fee 92513	Telehealth attendance by a public health physician in the practice of the public health physician's 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 management. **Fee:** $22.60 **Benefit:** 85% = $19.25 **Extended Medicare Safety Net Cap:** $67.80
Fee 92514	Telehealth attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan;

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	33. PUBLIC HEALTH PHYSICIAN – TELEHEALTH SERVICES
	(d) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation **Fee:** $49.40 **Benefit:** 85% = $42.00 **Extended Medicare Safety Net Cap:** $148.20
Fee 92515	Telehealth attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation. **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95
Fee 92516	Telehealth attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation. **Fee:** $140.80 **Benefit:** 85% = $119.70 **Extended Medicare Safety Net Cap:** $422.40

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	34. PUBLIC HEALTH PHYSICIAN – PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 34. Public health physician – Phone Services
Fee 92521	Phone attendance by a public health physician in the practice of the public health physician's 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 management; Where the attendance is not the first attendance for that particular clinical indication **Fee:** $22.60 **Benefit:** 85% = $19.25 **Extended Medicare Safety Net Cap:** $67.80

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	34. PUBLIC HEALTH PHYSICIAN – PHONE SERVICES
	Phone attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health-related issues, where the attendance is not the first attendance for those particular health-related issues, with appropriate documentation
Fee 92522	**Fee:** $49.40 **Benefit:** 85% = $42.00 **Extended Medicare Safety Net Cap:** $148.20

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	35. NEUROSURGERY ATTENDANCES – TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 35. Neurosurgery attendances – Telehealth Services
	Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist (other than a second or subsequent attendance in a single course of treatment). (See para AN.3.1 of explanatory notes to this Category)
Fee 92610	**Fee:** $149.80 **Benefit:** 85% = $127.35 **Extended Medicare Safety Net Cap:** $449.40
	Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist—a minor attendance after the first in a single course of treatment. (See para AN.3.1, AN.0.70 of explanatory notes to this Category)
Fee 92611	**Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25
	Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist—an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration. (See para AN.3.1, AN.0.70 of explanatory notes to this Category)
Fee 92612	**Fee:** $98.95 **Benefit:** 85% = $84.15 **Extended Medicare Safety Net Cap:** $296.85
	Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist—an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration. (See para AN.3.1, AN.0.70 of explanatory notes to this Category)
Fee 92613	**Fee:** $137.05 **Benefit:** 85% = $116.50 **Extended Medicare Safety Net Cap:** $411.15

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	35. NEUROSURGERY ATTENDANCES – TELEHEALTH SERVICES
Fee 92614	Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist—an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration. **Fee:** $174.50 **Benefit:** 85% = $148.35 **Extended Medicare Safety Net Cap:** $500.00

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	36. NEUROSURGERY ATTENDANCES – PHONE SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 36. Neurosurgery attendances – Phone Services
Fee 92618	Phone attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist—a minor attendance after the first in a single course of treatment. (See para AN.0.70 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 85% = $42.30 **Extended Medicare Safety Net Cap:** $149.25

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	37. SPECIALIST, ANAESTHESIA – TELEHEALTH SERVICES
	Group A40. Telehealth and phone attendance services
	Subgroup 37. Specialist, anaesthesia – Telehealth Services
Fee 92701	Telehealth attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and the formulation of a written patient management plan documented in the patient notes, and lasting more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 of the general medical services table apply) **Fee:** $98.95 **Benefit:** 85% = $84.15 **Extended Medicare Safety Net Cap:** $296.85

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	39. GP SEXUAL AND REPRODUCTIVE HEALTH CONSULTATION – TELEHEALTH SERVICE
	Group A40. Telehealth and phone attendance services
	Subgroup 39. GP Sexual and Reproductive Health Consultation – Telehealth Service
Fee 92715	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan;

	(d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
92716	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
Fee 92717	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $15.70 **Benefit:** 100% = $15.70 **Extended Medicare Safety Net Cap:** $47.10
Fee 92718	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation;

	(c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
92719	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
Fee 92720	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $34.25 **Benefit:** 100% = $34.25 **Extended Medicare Safety Net Cap:** $102.75
Fee 92721	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history;

	(b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
92722	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
Fee 92723	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 92724	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant:

	(a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
92725	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
Fee 92726	Telehealth attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10

	Group A40. Telehealth and phone attendance services
	Subgroup 40. GP Sexual and Reproductive Health Consultation – Phone Service
Fee 92731	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $19.60 **Benefit:** 100% = $19.60 **Extended Medicare Safety Net Cap:** $58.80
92732	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
Fee 92733	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care

	Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $15.70 **Benefit:** 100% = $15.70 **Extended Medicare Safety Net Cap:** $47.10
Fee 92734	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $42.85 **Benefit:** 100% = $42.85 **Extended Medicare Safety Net Cap:** $128.55
92735	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
Fee 92736	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 5 minutes in duration but not more than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan;

	(d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $34.25 **Benefit:** 100% = $34.25 **Extended Medicare Safety Net Cap:** $102.75
Fee 92737	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $82.90 **Benefit:** 100% = $82.90 **Extended Medicare Safety Net Cap:** $248.70
92738	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
Fee 92739	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 20 minutes in duration but not more than 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation;

	(c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05
Fee 92740	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $122.15 **Benefit:** 100% = $122.15 **Extended Medicare Safety Net Cap:** $366.45
92741	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
Fee 92742	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, lasting at least 40 minutes in duration if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history;

A40. TELEHEALTH AND PHONE ATTENDANCE SERVICES	40. GP SEXUAL AND REPRODUCTIVE HEALTH CONSULTATION – PHONE SERVICE
	(b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5, AN.1.1 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 100% = $97.70 **Extended Medicare Safety Net Cap:** $293.10

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	3. ASSESSING PATIENT SUITABILITY FOR A DOSE OF A COVID-19 VACCINE
	Group A44. General Practice Attendance for Assessing Patient Suitability for a COVID-19 Vaccine
	Subgroup 3. Assessing Patient Suitability for a Dose of a COVID-19 Vaccine
Fee 93644	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in a Modified Monash 1 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $44.45 **Benefit:** 85% = $37.80
Fee 93645	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in: (i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $48.80 **Benefit:** 85% = $41.50
Fee 93646	Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management;

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	3. ASSESSING PATIENT SUITABILITY FOR A DOSE OF A COVID-19 VACCINE
	(b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in a Modified Monash 1 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $35.65 **Benefit:** 85% = $30.35
Fee 93647	Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in: (i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $44.10 **Benefit:** 85% = $37.50

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	4. AFTER-HOURS ASSESSING PATIENT SUITABILITY FOR THE SECOND OR SUBSEQUENT DOSE OF A COVID-19 VACCINE
	Group A44. General Practice Attendance for Assessing Patient Suitability for a COVID-19 Vaccine
	Subgroup 4. After-Hours Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine
Fee 93653	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in a Modified Monash 1 area; (d) the service is rendered in an after-hours period (See para AN.44.1 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 85% = $51.30
Fee 93654	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant:

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	4. AFTER-HOURS ASSESSING PATIENT SUITABILITY FOR THE SECOND OR SUBSEQUENT DOSE OF A COVID-19 VACCINE
	(i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in: (i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area; (d) the service is rendered in an after-hours period (See para AN.44.1 of explanatory notes to this Category) **Fee:** $64.55 **Benefit:** 85% = $54.90
Fee 93655	Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in a Modified Monash 1 area; (d) the service is rendered in an after-hours period (See para AN.44.1 of explanatory notes to this Category) **Fee:** $48.60 **Benefit:** 85% = $41.35
Fee 93656	Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient's suitability for a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is provided at, or from, a practice location in:

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	4. AFTER-HOURS ASSESSING PATIENT SUITABILITY FOR THE SECOND OR SUBSEQUENT DOSE OF A COVID-19 VACCINE
	(i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area; (d) the service is rendered in an after-hours period (See para AN.44.1 of explanatory notes to this Category) **Fee:** $56.70 **Benefit:** 85% = $48.20

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	5. IN-DEPTH PATIENT ASSESSMENT FOR A PATIENT WHO HAS RECEIVED A VACCINE SUITABILITY ASSESSMENT SERVICE
	Group A44. General Practice Attendance for Assessing Patient Suitability for a COVID-19 Vaccine
	Subgroup 5. In-Depth Patient Assessment for a Patient who has Received a Vaccine Suitability Assessment Service
	Professional attendance by a general practitioner, if all of the following apply: (a) the service is associated with a service to which item 93644, 93645, 93653 or 93654 applies; (b) the service requires personal attendance by the general practitioner, lasting more than 10 minutes in duration, to provide in-depth clinical advice on the individual risks and benefits associated with receiving a COVID-19 vaccine; (c) one or both of the following is undertaken, where clinically relevant: (i) a detailed patient history; (ii) complex examination and management; (d) the service is bulk-billed
Fee 10660	(See para AN.44.1 of explanatory notes to this Category) **Fee:** $50.35 **Benefit:** 85% = $42.80
	Professional attendance by a medical practitioner (other than a general practitioner), if all of the following apply: (a) the service is associated with a service to which item 93646, 93647, 93655 or 93656 applies; (b) the service requires personal attendance by the medical practitioner (other than a general practitioner), lasting more than 10 minutes in duration, to provide in-depth clinical advice on the individual risks and benefits associated with receiving a COVID-19 vaccine; (c) one or both of the following is undertaken, where clinically relevant: (i) a detailed patient history; (ii) complex examination and management; (d) the service is bulk-billed
Fee 10661	(See para AN.44.1 of explanatory notes to this Category) **Fee:** $40.30 **Benefit:** 85% = $34.30

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	6. OFF-SITE PATIENT ASSESSMENT ON BEHALF OF A MEDICAL PRACTITIONER
	Group A44. General Practice Attendance for Assessing Patient Suitability for a COVID-19 Vaccine
	Subgroup 6. Off-Site Patient Assessment on Behalf of a Medical Practitioner
	Attendance by a relevant health professional on behalf of a medical practitioner for the purpose of assessing a patient's suitability for a dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant:
Fee 93660	

A44. GENERAL PRACTICE ATTENDANCE FOR ASSESSING PATIENT SUITABILITY FOR A COVID-19 VACCINE	6. OFF-SITE PATIENT ASSESSMENT ON BEHALF OF A MEDICAL PRACTITIONER
	(i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is not provided at a practice location; and (d) the service is provided from a practice location in a Modified Monash 1 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $27.05 **Benefit:** 85% = $23.00
Fee 93661	Attendance by a relevant health professional on behalf of a medical practitioner for the purpose of assessing a patient's suitability for a dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the service is bulk-billed; (c) the service is not provided at a practice location; and (d) the service is provided from a practice location in: (i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area (See para AN.44.1 of explanatory notes to this Category) **Fee:** $30.90 **Benefit:** 85% = $26.30