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Department of Health

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Category 2

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

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G.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.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also 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.

G.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. **The Department of Human Services** 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). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
- 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 public patients);
- iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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, the Department of Human Services may request its return from the practitioner concerned.

G.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 the Department of Human Services 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, the Department of Human Services will take recovery action.

The Department of Human Services (DHS) 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 DHS website.

G.2.1. 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 Department of Human Services to provide these services.

G.2.2. 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 the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services 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.

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.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

G.2.3. 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 the Department of Human Services (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.

G.2.4. 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.

G.2.5. CONTACT DETAILS FOR THE DEPARTMENT OF HUMAN SERVICES

Changes to Provider Contact Details
It is important that you contact the Department of Human Services 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 the Department of Human Services at:

Medicare
GPO Box 9822
in your capital city
or

By email: medicare.prov@medicareaustralia.gov.au

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

MBS Interpretations
The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Department of Human Services. Inquiries concerning matters of interpretation of MBS items should be directed to the Department of Human Services at Email: askmbs@humanservices.gov.au

or by phone on 132 150

G.3.1. PATIENT ELIGIBILITY FOR MEDICARE

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

G.3.2. MEDICARE CARDS

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words “INTERIM CARD” is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

G.3.3. VISITORS TO AUSTRALIA AND TEMPORARY RESIDENTS

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

G.3.4. RECIPROCAL HEALTH CARE AGREEMENTS

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy, Malta, Belgium and Slovenia.

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enroll with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:
- Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.

- Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered.

G.4.1. GENERAL PRACTICE

Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is

(a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for ***either*** the award of FRACGP ***or*** a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for ***either*** the award of FACRRM ***or*** a training program recognised by ACRRM as being of an equivalent standard.

A medical practitioner seeking recognition as an FRACGP should apply to the Department of Human Services, having completed an application form available from the Department of Human Services's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise the Department of Human Services when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on the Department of Human Services's website.

Vocational recognition of general practitioners

The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

(a) certification by the RACGP that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28 days, predominantly in general practice; and
- has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28, predominantly in general practice; and
- has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner
- is a Fellow of ACRRM; and
- has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP
Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:
Email at gprec@health.gov.au

Executive Assistant, ACRRM:
Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition
Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat
The General Practice Recognition Eligibility Committee
National Registration and Accreditation Scheme Policy Section
MDP 152
Department of Health
GPO Box 9848
CANBERRA ACT 2601
email address: gprec@health.gov.au

The Secretariat
The General Practice Recognition Appeal Committee
National Registration and Accreditation Scheme Policy Section
MDP 152
Department of Health
GPO Box 9848
CANBERRA ACT 2601
email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services CEO for processing.

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and
(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to The Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status
A medical practitioner may at any time request the Department of Human Services to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to the Department of Human Services that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.

A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-register, or for a new determination.

G.5.1. 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 the Department of Human Services' 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 rebates. Specialist trainees should consult the information available at the Department of Human Services' 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 the Department of Human Services' Medicare website.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

G.5.2. 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.

G.6.1. 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.

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 his or her 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 whichever is the longer.

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 18 months from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, 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.

G.7.1. BILLING PROCEDURES

The Department of Human Services website contains information on Medicare billing and claiming options. Please visit the Department of Human Services 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 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 on the one occasion and claims multiple Medicare items, the practitioner can choose to bulk bill some or all of those services. Where some but not all of the services are bulk billed a fee may be privately charged for the other service (or services) in excess of the Medicare rebate provided that that fee is only in relation to that service (or services).

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 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).

G.8.1. 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.

The Department of Human Services monitors health practitioners' claiming patterns. Where the Department of Human Services 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

G.8.2. 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).

G.8.3. 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'.

G.8.4. 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.

G.8.5. 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.

G.8.6. 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.

G.8.7. MEDICARE CLAIMS REVIEW PANEL

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 21965, 21997, 30214, 35534, 32501, 42783, 42786, 42789, 42792, 45019, 45020, 45051, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639.

Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed to:
The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

G.9.1. 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.

G.10.1. 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.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

Schedule fees are usually adjusted on an annual basis except for Pathology, Diagnostic Imaging and certain other items.

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 public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
   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'.

(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.

(c) **85% of the Schedule fee,** or the Schedule fee less $80.20 (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 National Healthcare Agreement.

A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, *but prior to admission or subsequent to discharge*, will attract benefits at the 85% or 100% level, not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph (i) above) attract benefits at the 85% level.

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. 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.

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. Patient's 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.

G.10.2. MEDICARE SAFETY NETS

The Medicare Safety Nets provide 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.

Original Medicare Safety Net:

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. The threshold from 1 January 2016 is $447.40. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (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 below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2016, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB(A) is $647.90. The threshold for all other singles and families in 2016 is $2,030.

The thresholds for both safety nets are usually indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on 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 the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

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. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

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 is calcualted as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

G.11.1. 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).

Enquiries about services not listed or on matters of interpretation should be directed to the Department of Human Services on 132 150.

G.11.2. 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)**".

G.12.1. 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 H*ealth Insurance Regulations 1975* specify that 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 assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
(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 – 12323 when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

Medical services in Categories 2 and 3 not included in G.12.1 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. the Department of Human Services must be satisfied with the employment and supervision arrangements. 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.

G.12.3. MASS IMMUNISATION

Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation.

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G.13.1. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

Services not attracting benefits

(a) telephone consultations;
(b) issue of repeat prescriptions when the patient does not attend the surgery in person;
(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
(d) non-therapeutic cosmetic surgery;
(e) 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, or in connection with, an injection of blood or ablood product that is autologous.

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) vertebroplasty

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 Papanicolaou 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 examination being a requisite for Social Security benefits or allowances;
(g) 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 on screening for the Prevention of Cervical Cancer (endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council) is as follows:

(a) an examination interval of two years for a person who has no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
(b) cessation of cervical smears at 70 years for a person who has had two normal results within the last five years. A person over 70 who has never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: 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.

G.14.1. 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.

G.14.2. 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.

G.14.3. 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.

G.14.4. 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.

G.14.5. 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.

G.15.1. 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.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the DHS website.

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

CATEGORY 2

SUMMARY OF CHANGES FROM 1/12/2016

The 1/12/2016 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

New items from 1/12/2016

11220

Amended Descriptions from 1/12/2016

11219

D.1.1. ELECTROENCEPHALOGRAPHY (EEG), PROLONGED RECORDING - (ITEM 11003)

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT).

D.1.2. ELECTROENCEPHALOGRAPHY (EEG), AMBULATORY OR VIDEO - (ITEMS 11004 AND 11005)

Items 11004 and 11005 cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

D.1.3. NEUROMUSCULAR DIAGNOSIS - (ITEM 11012)

Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

D.1.4. INVESTIGATION OF CENTRAL NERVOUS SYSTEM EVOKED RESPONSES - (ITEMS 11024 AND 11027)

In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

NOTE: Items 11024 and 11027 are not intended to cover bio-feedback techniques.

D.1.5. ELECTRORETINOGRAPHY - (ITEMS 11204, 11205, 11210 AND 11211)

Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

D.1.6. COMPUTERISED PERIMETRY PRINTED RESULTS - (ITEMS 11221 TO 11225)

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 - 11225 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

D.1.7. COMPUTERISED PERIMETRY - (ITEMS 11222 AND 11225)

Item 11222 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11225 for unilateral procedures should be claimed, where appropriate.

Claims for benefits in respect of Items 11222 and 11225 should be accompanied by clinical details confirming the presence of one of the conditions identified in the item.

Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be in a sealed envelope marked 'Medical-in Confidence' addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

D.1.8. ORBITAL CONTENTS - (ITEMS 11240, 11241, 11242 AND 11243)

Items 11240 and 11241 may only be utilised once per patient per practitioner. Where an additional service is necessary items 11242 and 11243 should be utilised.

Partial coherence interferometry may also be referred to as optical (or ocular) coherence biometry or laser Doppler interferometry.

D.1.9. BRAIN STEM EVOKED RESPONSE AUDIOMETRY - (ITEM 11300)

Item 11300 can be claimed for the programming of a cochlear speech processor.

D.1.10. ELECTROCOCHLEOGRAPHY - (ITEM 11304)

Item 11304 refers to electrocochleography with insertion of electrodes through the tympanic membrane.

D.1.11. NON-DETERMINATE AUDIOMETRY - (ITEM 11306)

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11318 when not performed under the conditions set out in paragraph D1.13.

D.1.12. AUDIOLOGY SERVICES - (ITEMS 11309 TO 11318)

A medical service specified in Items 11309 to 11318 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;
(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

D.1.13. OTO-ACOUSTIC EMISSION AUDIOMETRY - (ITEM 11332)

Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

D.1.14. RESPIRATORY FUNCTION TESTS - (ITEM 11503)

The investigations listed hereunder would attract benefits under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

(a) Carbon monoxide diffusing capacity by any method
(b) Absolute lung volumes by any method
(c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
(d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure
(e) Measurement of airway or pulmonary resistance by any method
(f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
(g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
(h) Measurement of the resistance of the anterior nares or pharynx
(i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents, non-isotonic fluids or powder and post-bronchodilator spirometry
(j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
(k) Tests of distribution of ventilation involving inhalation of inert gases
(l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
(m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
(n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration
(o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
(p) Monitoring pulmonary arterial pressure at rest or during exercise
(q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes
(r) Measurement of the respiratory muscle endurance/fatigability by any technique
(s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
(t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
(u) Inhalation provocation testing to specific sensitising agents

(v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator

D.1.15. CAPSULE ENDOSCOPY - (ITEM 11820 AND 11823)

Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy.

Conjoint committee

The Conjoint Committee comprises representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). For the purposes of Items 11820 and 11823, specialists or consultant physicians performing this procedure must have endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, and the Department of Human Services notified of that recognition.

D.1.16. ADMINISTRATION OF THYROTROPIN ALFA-RCH FOR THE DETECTION OF RECURRENT WELL-DIFFERENTIATED THYROID CANCER - (ITEM 12201)

Thyrotropin alfa-rch is a diagnostic agent that allows patients to remain on thyroid hormone therapy while being assessed for recurrent cancer. This item was introduced following an assessment by the Medical Services Advisory Committee (MSAC) of the available evidence relating to the safety, effectiveness and cost-effectiveness of thyrotropin alfa-rch. MSAC found that the use of thyrotropin alfa-rch is associated with a lower diagnostic accuracy than when the patient has withdrawn from thyroid hormone therapy. Accordingly, benefits are payable under the item only for patients in whom thyroid hormone therapy withdrawal is medically contraindicated and where concurrent whole body study using radioactive iodine and serum thyroglobulin are undertaken. Services provided to patients who do not demonstrate the indications set out in item 12201 do not attract benefits under the item.

"**Severe psychiatric illness**" is defined as patients with a severe pre-existing psychiatric illness who are currently under specialist psychiatric care.

The item includes the cost of supplying thyrotropin alfa-rch and the equivalent of a subsequent specialist attendance. "Administration" means an attendance by the specialist or consultant physician (the administering practitioner) that includes:

- an assessment that the patient meets the criteria prescribed by the item;
  the supply of thyrotropin alfa-rch;
- ensuring that thyrotropin alfa-rch is injected (either by the administering practitioner or by another practitioner) in two doses at 24 hour intervals, with the second dose being administered 72 hours prior to whole body study with radioactive iodine and serum thyroglobulin test; and
- arranging the whole body radioactive iodine study and the serum thyroglobulin test.

Where thyrotropin alfa-rch is injected by the administering practitioner, benefits are not payable for an attendance on the day the second dose is administered. Where thyrotropin alfa-rch is injected by: a general practitioner - benefits are payable under a Level A consultation (item 3); other practitioners - benefits are payable under item 52.

D.1.17. INVESTIGATIONS FOR SLEEP APNOEA - (ITEMS 12203, 12207, 12210, 12213, 12215, 12217 AND 12250)

Claims for benefits in respect of items 12207, 12215 and 12217 should be accompanied by clinical details confirming the presence of the conditions set out above. Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked "Medical-in-Confidence" to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

In relation to item 12250 for home-based sleep studies, the investigation cannot be provided on the same occasion as a service described in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203.

Where the date of service for item 12250 is the same as the date of service of any items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203, for a benefit to be payable, there must be written notation on the account, identifying that the

service under any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 was not provided on the same occasion as item 12250 and was not for a home-based sleep study.

The correct date to specify on the account for item 12250 is the day the home-based sleep study was completed (as opposed to the day it was initiated).

D.1.18. BONE DENSITOMETRY - (ITEMS 12306 TO 12323)

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

Item 12323 enables the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. The Government has decided to expand access to Medicare subsidised bone mineral density testing to coincide with the expanded eligibility for the osteoporosis medication 'alendronate' under the Pharmaceutical Benefits Scheme.

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report; all performed by a specialist or consultant physician in the practice of his or her specialty. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals

Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12309, 12312, 12315, 12318, 12321 and 12323.

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

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

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

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

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

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

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

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

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

For Items 12312 and 12318
(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;
for a period anticipated to last for at least 4 months.
Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

For Items 12312 and 12318
(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.
(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

For Items 12315 and 12318
A malabsorptive disorder is defined as one or more of the following:
(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
(c) histologically proven Coeliac disease.

D.1.19. RETINAL PHOTOGRAPHY WITH A NON-MYDRIATIC RETINAL CAMERA

This service is separated into two items, MBS item 12325 and MBS item 12326, in line with NHMRC guidelines' recommended frequency of repeat testing in persons of Aboriginal andTorres Strait Islander descent and the general population.

This item is intended for the provision of retinal photography with a non-mydriatic retinal camera. Mydriasis is permitted if adequate photographs cannot be obtained through an undiated pupil.

Presenting distance vision means unaided distance vision or the vision obtained with the current spectacles or contact lenses, if normally worn for distance vision.

Detection of any diabetic retinopathy should be followed by referral to an optometrist or ophthalmologist in accordance with the NHMRC guidelines.

Where images are inadequate quality for detection of diabetic retinopathy, referral to an optometrist or ophthalmologist for further assessment is indicated.

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.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also 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.

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 1 - NEUROLOGY

11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) **Fee:** $123.10	**Benefit:** 75% = $92.35	85% = $104.65
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.1 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11004	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11005	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $167.00	**Benefit:** 75% = $125.25	85% = $141.95
11009	ELECTROCORTICOGRAPHY **Fee:** $227.75	**Benefit:** 75% = $170.85	85% = $193.60
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) *(See para D1.3 of explanatory notes to this Category)* **Fee:** $112.00	**Benefit:** 75% = $84.00	85% = $95.20
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $149.90	**Benefit:** 75% = $112.45	85% = $127.45
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $223.95	**Benefit:** 75% = $168.00	85% = $190.40
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $149.90	**Benefit:** 75% = $112.45	85% = $127.45
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies *(See para D1.4 of explanatory notes to this Category)* **Fee:** $113.85	**Benefit:** 75% = $85.40	85% = $96.80
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies *(See para D1.4 of explanatory notes to this Category)* **Fee:** $168.90	**Benefit:** 75% = $126.70	85% = $143.60

	SUBGROUP 2 - OPHTHALMOLOGY
11200	PROVOCATIVE TEST OR TESTS FOR OPEN ANGLE GLAUCOMA, including water drinking **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11215	RETINAL ANGIOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $123.00 **Benefit:** 75% = $92.25 85% = $104.55
11218	RETINAL ANGIOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $151.95 **Benefit:** 75% = $114.00 85% = $129.20
Amend 11219	OPTICAL COHERENCE TOMOGRAPHY to determine if the requirements relating to: a) age related macular degeneration for access to initial treatment with ranibizumab or aflibercept; or b) diabetic macular oedema for access to initial treatment with ranibizumab, aflibercept or dexamethasone; or c) central or branch retinal vein occlusion for access to initial treatment with ranibizumab or aflibercept; or d) vitreomacular traction for access to initial treatment with ocriplasmin; under the pharmaceutical benefits scheme are fulfilled. Maximum of one service in a 12 month period **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
New 11220	OPTICAL COHERENCE TOMOGRAPHY for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin. Maximum of one service per eye per lifetime. **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11224 applies) ***in any 12 month period*** *(See para D1.6 of explanatory notes to this Category)* **Fee:** $67.75 **Benefit:** 75% = $50.85 85% = $57.60
11222	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which Item 11221 applies due to presence of one of the following conditions:-*** . established glaucoma (where surgery may be required within a six month period) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease - ***each additional examination*** *(See para D1.6 and D1.7 of explanatory notes to this Category)* **Fee:** $67.75 **Benefit:** 75% = $50.85 85% = $57.60

11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11221 applies) ***in any 12 month period*** *(See para D1.6 of explanatory notes to this Category)* **Fee:** $40.85 **Benefit:** 75% = $30.65 85% = $34.75
11225	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions:-*** . established glaucoma (where surgery may be required within a 6 month period) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease - ***each additional examination*** *(See para D1.6 and D1.7 of explanatory notes to this Category)* **Fee:** $40.85 **Benefit:** 75% = $30.65 85% = $34.75
11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report **Fee:** $122.75 **Benefit:** 75% = $92.10 85% = $104.35
11237	OCULAR CONTENTS, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 apply **Fee:** $81.45 **Benefit:** 75% = $61.10 85% = $69.25
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $81.45 **Benefit:** 75% = $61.10 85% = $69.25
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $103.65 **Benefit:** 75% = $77.75 85% = $88.15
11242	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $80.10 **Benefit:** 75% = $60.10 85% = $68.10
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $80.10 **Benefit:** 75% = $60.10 85% = $68.10
11244	**Orbital contents,** diagnostic B-scan of, by a specialist practising in his or her speciality of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies. **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
	SUBGROUP 3 - OTOLARYNGOLOGY
11300	BRAIN stem evoked response audiometry (Anaes.) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60

	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears *(See para D1.10 of explanatory notes to this Category)*		
11304	**Fee:** $316.95	**Benefit:** 75% = $237.75	85% = $269.45
	Nondeterminate AUDIOMETRY *(See para D1.11 of explanatory notes to this Category)*		
11306	**Fee:** $21.90	**Benefit:** 75% = $16.45	85% = $18.65
	AUDIOGRAM, air conduction *(See para D1.12 of explanatory notes to this Category)*		
11309	**Fee:** $26.30	**Benefit:** 75% = $19.75	85% = $22.40
	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination *(See para D1.12 of explanatory notes to this Category)*		
11312	**Fee:** $37.15	**Benefit:** 75% = $27.90	85% = $31.60
	AUDIOGRAM, air and bone conduction and speech *(See para D1.12 of explanatory notes to this Category)*		
11315	**Fee:** $49.20	**Benefit:** 75% = $36.90	85% = $41.85
	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests *(See para D1.12 of explanatory notes to this Category)*		
11318	**Fee:** $60.75	**Benefit:** 75% = $45.60	85% = $51.65
	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies		
11324	**Fee:** $32.85	**Benefit:** 75% = $24.65	85% = $27.95
	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies		
11327	**Fee:** $19.75	**Benefit:** 75% = $14.85	85% = $16.80
	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period		
11330	**Fee:** $7.90	**Benefit:** 75% = $5.95	85% = $6.75
	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity: or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where:- - the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion *(See para D1.13 of explanatory notes to this Category)*		
11332	**Fee:** $58.55	**Benefit:** 75% = $43.95	85% = $49.80
	CALORIC TEST OF LABYRINTH OR LABYRINTHS		
11333	**Fee:** $44.60	**Benefit:** 75% = $33.45	85% = $37.95
	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS		
11336	**Fee:** $44.60	**Benefit:** 75% = $33.45	85% = $37.95
	ELECTRONYSTAGMOGRAPHY		
11339	**Fee:** $44.60	**Benefit:** 75% = $33.45	85% = $37.95

	SUBGROUP 4 - RESPIRATORY
11503	**Measurement of the:** (a) mechanical or gas exchange function of the respiratory system; or (b) respiratory muscle function; or (c) ventilatory control mechanisms. Various measurement parameters may be used including any of the following: (a) pressures; (b) volumes; (c) flow; (d) gas concentrations in inspired or expired air; (e) alveolar gas or blood; (f) electrical activity of muscles. The tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital. Each occasion at which 1 or more such tests are performed, not being a service associated with a service to which item 22018 applies. *(See para D1.14 of explanatory notes to this Category)* **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed **Fee:** $20.55 **Benefit:** 75% = $15.45 85% = $17.50
11509	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed **Fee:** $35.65 **Benefit:** 75% = $26.75 85% = $30.35
11512	CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed **Fee:** $61.75 **Benefit:** 75% = $46.35 85% = $52.50
	SUBGROUP 5 - VASCULAR
11600	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of general anaesthesia) *(See para T1.10 and T1.11 of explanatory notes to this Category)* **Fee:** $69.30 **Benefit:** 75% = $52.00 85% = $58.95
11602	**Investigation of venous reflux or obstruction** in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsava manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 or 32501 applies - hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of two examinations in a 12 month period, not to be used in conjunction with sclerotherapy. **Fee:** $57.75 **Benefit:** 75% = $43.35 85% = $49.10
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography) - examination, hard copy trace and written report, not being a service associated with a service to which item 32500 or 32501 applies. **Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease, hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 or 32501 applies. **Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35

11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report. **Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20
11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report. **Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20
11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report. **Fee:** $112.40 **Benefit:** 75% = $84.30 85% = $95.55
11614	TRANSCRANIAL DOPPLER, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, not associated with a service to which item 55280 applies. **Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing. **Fee:** $75.90 **Benefit:** 75% = $56.95 85% = $64.55
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $228.65 **Benefit:** 75% = $171.50 85% = $194.40
	SUBGROUP 6 - CARDIOVASCULAR
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report **Fee:** $31.25 **Benefit:** 75% = $23.45 85% = $26.60 **Extended Medicare Safety Net Cap:** $25.00
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion **Fee:** $15.55 **Benefit:** 75% = $11.70 85% = $13.25
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $15.55 **Benefit:** 75% = $11.70 85% = $13.25
11708	**Continuous ECG recording** of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), **not in association with ambulatory blood pressure monitoring**, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician. Not being a service to which item 11709 applies. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $127.90 **Benefit:** 75% = $95.95 85% = $108.75
11709	**Continuous ECG recording** (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), **not in association with ambulatory blood pressure monitoring**, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $167.45 **Benefit:** 75% = $125.60 85% = $142.35
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $51.90 **Benefit:** 75% = $38.95 85% = $44.15

11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $28.30	**Benefit:** 75% = $21.25	85% = $24.10
11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator **Fee:** $152.15	**Benefit:** 75% = $114.15	85% = $129.35
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician **Fee:** $69.75	**Benefit:** 75% = $52.35	85% = $59.30
11715	BLOOD DYE DILUTION INDICATOR TEST **Fee:** $120.75	**Benefit:** 75% = $90.60	85% = $102.65
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700, 11719, 11720, 11721, 11725 or 11726 applies **Fee:** $34.75	**Benefit:** 75% = $26.10	85% = $29.55
11719	IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) or arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period **Fee:** $66.85	**Benefit:** 75% = $50.15	85% = $56.85
11720	IMPLANTED PACEMAKER TESTING, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11718 or 11721 applies. **Fee:** $66.85	**Benefit:** 75% = $50.15	85% = $56.85
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700, 11718 11719, 11720, 11725 or 11726 applies **Fee:** $69.75	**Benefit:** 75% = $52.35	85% = $59.30
11722	IMPLANTED ECG LOOP RECORDING, for investigation of recurrent unexplained syncope, including re-programming of device, retrieval of stored data, analysis, interpretation and report, not in association with item 38285 **Fee:** $34.75	**Benefit:** 75% = $26.10	85% = $29.55
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator **Fee:** $168.90	**Benefit:** 75% = $126.70	85% = $143.60
11725	IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period. Payable only once in any 12 month period **Fee:** $189.50	**Benefit:** 75% = $142.15	85% = $161.10
11726	IMPLANTED DEFIBRILLATOR TESTING with patient attendance following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies. **Fee:** $94.75	**Benefit:** 75% = $71.10	85% = $80.55
11727	IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to which item 11700, 11718, 11719, 11720, 11721, 11725 or 11726 applies **Fee:** $94.75	**Benefit:** 75% = $71.10	85% = $80.55

	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30
11801	CLINICAL ASSESSMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE that involves 48 hour catheter-free wireless ambulatory oesophageal pH monitoring including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if (a) a cathetter-based ambulatory oesophageal pH-mnitoring: (i) has been attempted on the patient but failed due to clinical complications, or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the services is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. Not in association with another item in Category 2, sub-group 7 (Anaes.) **Fee:** $263.00 **Benefit:** 75% = $197.25 85% = $223.55
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the patient to whom the service is provided: (i) has recurrent or persistent bleeding; and (ii) is anaemic or has active bleeding; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with balloon enteroscopy *(See para D1.15 of explanatory notes to this Category)* **Fee:** $2,039.20 **Benefit:** 75% = $1,529.40 85% = $1,959.00
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy. *(See para D1.15 of explanatory notes to this Category)* **Fee:** $2,039.20 **Benefit:** 75% = $1,529.40 85% = $1,959.00
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $186.80 **Benefit:** 75% = $140.10 85% = $158.80
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $249.75 **Benefit:** 75% = $187.35 85% = $212.30
	SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11919 applies **Fee:** $27.55 **Benefit:** 75% = $20.70 85% = $23.45
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which any of items 11012-11027, 11912, 11915, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45

11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which any of items 11012-11027, 11909, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or any item in Group I3 applies **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012-11027, 11903, 11915, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012-11027, 11903, 11909, 11912, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply. (Anaes.) **Fee:** $428.35 **Benefit:** 75% = $321.30 85% = $364.10
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.) **Fee:** $428.35 **Benefit:** 75% = $321.30 85% = $364.10
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens **Fee:** $75.05 **Benefit:** 75% = $56.30 85% = $63.80
	SUBGROUP 9 - ALLERGY TESTING
12000	Skin sensitivity testing for allergens, using one to 20 allergens, other than a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
12003	Skin sensitivity testing for allergens, using more than 20 allergens, other than a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies **Fee:** $58.85 **Benefit:** 75% = $44.15 85% = $50.05
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens **Fee:** $20.80 **Benefit:** 75% = $15.60 85% = $17.70
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens **Fee:** $70.30 **Benefit:** 75% = $52.75 85% = $59.80
12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens but not more than 75 allergens **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20
12022	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 75 allergens but not more than 100 allergens **Fee:** $135.65 **Benefit:** 75% = $101.75 85% = $115.35
12024	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 100 allergens **Fee:** $154.50 **Benefit:** 75% = $115.90 85% = $131.35
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $37.20 **Benefit:** 75% = $27.90 85% = $31.65

	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient who: (a) has had a total thyroidectomy and one ablative dose of radioactive iodine; and (b) is maintained on thyroid hormone therapy; and (c) is at risk of recurrence; and (d) on at least one previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy did not have evidence of well differentiated thyroid cancer; and (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contraindicated because the patient has: - unstable coronary artery disease; or - hypopituitarism ; or - a high risk of relapse or exacerbation of a previous severe psychiatric illness payable once only in any twelve month period. *(See para D1.16 of explanatory notes to this Category)*
12201	**Fee:** $2,392.90 **Benefit:** 75% = $1,794.70 85% = $2,312.70
	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient - payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period. *(See para D1.17 of explanatory notes to this Category)*
12203	**Fee:** $588.00 **Benefit:** 75% = $441.00 85% = $507.80
	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient ***where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies*** for the adjustment and/or testing of the effectiveness of a *positive pressure ventilatory support device* (other than nasal continuous positive airway pressure) in sleep, in a *patient with severe cardio-respiratory failure*, and where previous studies have demonstrated failure of continuous positive airway pressure or oxygen - **each additional investigation** *(See para D1.17 of explanatory notes to this Category)*
12207	**Fee:** $588.00 **Benefit:** 75% = $441.00 85% = $507.80

12210	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $701.85 **Benefit:** 75% = $526.40 85% = $621.65
12213	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $632.30 **Benefit:** 75% = $474.25 85% = $552.10
12215	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. *(See para D1.17 of explanatory notes to this Category)* **Fee:** $701.85 **Benefit:** 75% = $526.40 85% = $621.65

DIAGNOSTIC		OTHER
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED BETWEEN 12 AND 18 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. *(See para D1.17 of explanatory notes to this Category)*	
12217	**Fee:** $632.30 **Benefit:** 75% = $474.25 85% = $552.10	
	Overnight investigation for sleep apnoea for a period of at least 8 hours duration for a patient aged 18 years or more, if all of the following requirements are met: (a) the patient has, before the overnight investigation, been referred to a qualified adult sleep medicine practitioner by a medical practitioner whose clinical opinion is that there is a high probability that the patient has obstructive sleep apnoea; and (b) the investigation takes place after the qualified adult sleep medicine practitioner has: (i) confirmed the necessity for the investigation; and (ii) communicated this confirmation to the referring medical practitioner; and (c) during a period of sleep, the investigation involves recording a minimum of seven physiological parameters which must include: (i) continuous electro-encephalogram (EEG); and (ii) continuous electro-cardiogram (ECG; and (iii) airflow; and (iv) thoraco-abdominal movement; and (v) oxygen saturation; and (vi) 2 or more of the following: (A) electro-oculogram (EOG); (B) chin electro-myogram (EMG); (C) body position; and (d) in the report on of the investigation, the qualified adult sleep medicine practitioner uses the data specified in paragraph (c) to: (i) analyse sleep stage, arousals and respiratory events; and (ii) assess clinically significant alteration in heart rate; and (e) the qualified adult sleep medicine practitioner: (i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and (ii) personally analyses the data and writes the report on the results of the investigation; (f) the investigation is not provided to the patient on the same occasion as a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 is provided to the patient Payable only once in a 12 month period *(See para D1.17 of explanatory notes to this Category)*	
12250	**Fee:** $335.30 **Benefit:** 75% = $251.50 85% = $285.05	

DIAGNOSTIC		OTHER
12306	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12309	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12312	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12315	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination) *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12318	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination) *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	

DIAGNOSTIC		OTHER
12321	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the **measurement** of bone density 12 months following a significant change in therapy for: . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. Measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination). *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12323	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry** or **quantitative computerised tomography**, for the measurement of bone mineral density, for a person aged 70 years or over. Measurement of 2 or more sites - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination). *(See para D1.18 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12325	Assessment of visual acuity and bilateral retinal photography with a non mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the patient is of Aboriginal and Torres Strait Islander descent; and (b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (c) this item and item 12326 have not applied to the patient in the preceding 12 months; and (d) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation *(See para D1.19 of explanatory notes to this Category)* **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50	
12326	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (b) this item and item 12325 have not applied to the patient in the preceding 24 months; and (c) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation *(See para D1.19 of explanatory notes to this Category)* **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50	

	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)		
12500	BLOOD VOLUME ESTIMATION **Fee:** $216.65	**Benefit:** 75% = $162.50	85% = $184.20
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $424.75	**Benefit:** 75% = $318.60	85% = $361.05
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $303.30	**Benefit:** 75% = $227.50	85% = $257.85
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $216.65	**Benefit:** 75% = $162.50	85% = $184.20
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope **Fee:** $105.05	**Benefit:** 75% = $78.80	85% = $89.30
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes **Fee:** $229.85	**Benefit:** 75% = $172.40	85% = $195.40
12518	THYROID UPTAKE (using probe) **Fee:** $105.05	**Benefit:** 75% = $78.80	85% = $89.30
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $126.65	**Benefit:** 75% = $95.00	85% = $107.70
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $158.35	**Benefit:** 75% = $118.80	85% = $134.60
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $84.95	**Benefit:** 75% = $63.75	85% = $72.25
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies **Fee:** $126.65	**Benefit:** 75% = $95.00	85% = $107.70
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, for either:- (a) the confirmation of *Helicobacter pylori* colonisation, OR (b) the monitoring of the success of eradication of *Helicobacter pylori*. not being a service to which 66900 applies **Fee:** $84.65	**Benefit:** 75% = $63.50	85% = $72.00

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