



Changes to MBS Items for Obstetrics Services Frequently Asked Questions

Last updated: 26/10/2017

Effective from 1 November 2017

The changes support the Government's priority of ensuring that Medicare funded services are safe, clinically effective and cost-effective. These changes are based on recommendations of the Medicare Benefits Schedule (MBS) Review Taskforce.

The changes will align MBS obstetrics items with clinical best practice and reduce inappropriate claiming of MBS items. The complete list of amendments to current MBS items and new items relating to obstetrics is at **Attachment 1**.

When will the changes to Obstetrics items come into effect?

The changes to obstetrics items will commence on 1 November 2017.

How will the changes to MBS Obstetrics items affect patients?

The changes to obstetrics items will ensure that women who choose to give birth as a private patient each year will receive an increase in MBS benefits for the planning and management of their pregnancy.

The changes will also ensure patients receiving private obstetric services will receive a mental health assessment during pregnancy and all patients who see their GP or obstetrician for their 6 week check-up will receive a mental health assessment, improving early detection and intervention.

How will the new requirements be monitored?

Obstetrics items will be subject to MBS compliance processes and activities, including random and targeted audits which may require a provider to submit evidence about the services claimed.

PLANNING AND MANAGEMENT OF PREGNANCY (Items 16590 and 16591)

Summary of changes:

- Practitioners will only be able to bill items 16590 or 16591 once the pregnancy has progressed beyond 28 weeks.
- A mental health assessment is to be offered to patients as part of the services.
- Practitioners billing item 16590 will be required to have privileges for intrapartum care in a hospital or birth centre and intend to undertake the delivery.
- The fee for item 16590 will be increased by 15% to \$372.75.

Why has the timeframe in which a practitioner can claim planning and management items 16590 and 16591 been delayed from 20 weeks to 28 weeks?

Item 16590 is for the planning and management of pregnancy where the doctor intends to undertake the birth for a privately admitted patient. Item 16591 is for the planning and



management of pregnancy where the doctor **does not** intend to undertake the birth but **does** intend to provide antenatal care to the patient.

Delaying when item 16590 and 16591 can be claimed from 20 weeks to 28 weeks will ensure that a model of care is established. The changes to 16590 also include the requirement that the provider has privileges for intrapartum care in a hospital.

The changes seek to clarify the intent of the item for providers, reduce inappropriate claiming and encourage continuity of care.

How will the changes to 16590 and 16591 affect current obstetric patients?

Existing patients that have not been billed prior to 1 November 2017 will be subject to the new requirements, and should not be billed until the pregnancy has progressed beyond 28 weeks. The MBS schedule fee for item 16590 will increase to \$372.75 in recognition that the medical practitioner must be continuously available during the third trimester of the pregnancy.

NEW REQUIREMENTS FOR MENTAL HEALTH ASSESSMENTS (Items 16590, 16591, and 16407)

What are the expectations for mental health assessments and which items do they apply to?

MBS items for the planning and management of pregnancy (16590 and 16951), and for postnatal consultations between 4-8 weeks (16407), now include an expectation that a mental health assessment be offered by the clinician or another suitably qualified health professional.

This aims to ensure:

- early identification of risk factors that may increase a patient's likelihood of experiencing mental health disorders in the perinatal period, as well as the presence of any symptoms of depression or anxiety, and
- to enable monitoring or referral for appropriate assessment, support and treatment.

It is intended that drug and alcohol misuse be taken into consideration in the mental health assessment of the patient in order to facilitate education about the inherent risks of drug and alcohol misuse in pregnancy. It is not the intention to require that the mental health assessment include drug and alcohol testing of the patient (e.g. the provision of blood or urine samples).

What if a patient does not want to undergo a mental health assessment?

It is expected that a mental health assessment is offered to the patient as part of the service - however - if the patient chooses not to have a mental health assessment, they would not be disadvantaged.

What guidance should providers follow for the mental health assessments?

The MBS does not prescribe the method by which health professionals undertake mental health assessments for obstetric patients.

However, it is recommended that mental health assessments under 16590, 16591, and 16407 be conducted in accordance with appropriate National Clinical Guidelines, such as



the *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline* – October 2017, Centre for Perinatal Excellence.

Will practitioners be required to keep records of the mental health assessments?

Yes. Results of the mental health assessment must be recorded in the patient's medical record.

A record of a patient's decision not to undergo a mental health assessment must be recorded in the patient's clinical notes.

COMPLEX BIRTH ITEM 16522

Summary of changes:

- The descriptor for item 16522 has been amended to include detailed clinical requirements.

Why have changes been made to the complex birth item 16522?

The Medicare Benefits Schedule Review Taskforce Review of Obstetrics found that there was a variation in the number of straight forward labour and deliveries (item 16519) claimed compared with the number of complex labour and deliveries (item 16522) across states and territories that is not explained by clinical factors. The item descriptor for item 16522 now clearly specifies the circumstances that would constitute a complex birth to provide clarity to providers.

What is covered under the complex birth item 16522?

The item descriptor for the management of labour and complex birth on or after 23.0 weeks gestation explicitly states the clinical indications for this item, , where in the course of antenatal supervision or intrapartum management, 1 or more of the following conditions is present:

- (a) fetal loss;
- (b) multiple pregnancy;
- (c) antepartum haemorrhage that is:
 - (i) of greater than 200 ml; or
 - (ii) associated with disseminated intravascular coagulation;
- (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os;
- (e) baby with a birth weight less than or equal to 2,500 g;
- (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section;
- (g) trial of vaginal breech birth where there has been a planned vaginal breech birth;
- (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix);
- (i) acute fetal compromise evidenced by:
 - (i) scalp pH less than 7.15; or
 - (ii) scalp lactate greater than 4.0;
- (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities:
 - (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);
 - (ii) absent baseline variability (less than 3 bpm);
 - (iii) sinusoidal pattern;
 - (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;
 - (v) late decelerations;



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- (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:
- (i) at least 2+ proteinuria on urinalysis; or
 - (ii) protein-creatinine ratio greater than 30 mg/mmol; or
 - (iii) platelet count less than $150 \times 10^9/L$; or
 - (iv) uric acid greater than 0.36 mmol/L;
- (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring;
- (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:
- (i) the patient requiring hospitalisation; or
 - (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or
 - (iii) the patient having a GP mental health treatment plan; or
 - (iv) the patient having a management plan prepared in accordance with item 291;
- (n) disclosure or evidence of domestic violence;
- (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:
- (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;
 - (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);
 - (iii) previous renal or liver transplant;
 - (iv) renal dialysis;
 - (v) chronic liver disease with documented oesophageal varices;
 - (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);
 - (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;
 - (viii) maternal height of less than 148 cm;
 - (ix) a body mass index greater than or equal to 40;
 - (x) pre-existing diabetes mellitus on medication prior to pregnancy;
 - (xi) thyrotoxicosis requiring medication;
 - (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
 - (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;
 - (xiv) HIV, hepatitis B or hepatitis C carrier status positive;
 - (xv) red cell or platelet iso-immunisation;
 - (xvi) cancer with metastatic disease;
 - (xvii) illicit drug misuse during pregnancy

The complex birth item has been restricted to an in-hospital only service and continues to include postnatal care for 7 days.

FEES FOR BIRTH ITEMS

Summary of changes:

From 1 November 2017, the fees for certain birth items will be amended.

- Item 16515 (vaginal birth) fee will change from \$450.65 to \$630.85
- Item 16520 (caesarean section) fee will change from \$811.05 to \$630.85
- Item 16527 (vaginal birth) fee will change from \$450.65 to \$630.85
- Item 16528 (caesarean section) fee will change from \$811.05 to \$630.85

Why are the MBS schedule fees for birth items 16515, 16520, 16527, and 16528 changing?

Items 16515 (vaginal birth) and 16520 (caesarean section) are for the management of a birth where the patient has been transferred by another medical practitioner and the doctor undertaking the birth has not provided any of the antenatal care.



Items 16527 (vaginal birth) and 16528 (caesarean section) are for the management of a birth where the patient has been transferred by a participating midwife and the doctor undertaking the birth has not provided any of the antenatal care.

The schedule fees for items 16515, 16520, 16527 and 16528 will be aligned with the principal birth item (16519 – Management of birth by any means) which does not distinguish between a vaginal and operative birth. The new fee is set in between the current fees for vaginal and caesarean births.

SECOND TRIMESTER FETAL LOSS

Summary of changes:

- Item 16525 for the management of pregnancy loss will be deleted and replaced with two separate items for pregnancy loss occurring in specified periods.

What are the changes to the management of second trimester fetal loss?

MBS item 16525 for the management of pregnancy loss will be deleted and two new items will be introduced.

New item 16530 will be for the management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, and will have a schedule fee of \$384.35, in line with the current item for fetal loss.

New item 16531 will be for the management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation. This service will be restricted to in-hospital only and will attract a higher fee of \$768.70 in recognition of the additional time and complexity associated with the management of late second trimester fetal loss.

The changes seek to encourage more private obstetricians to provide this service and improve continuity of care, rather than transferring the patient to the public system.

The complex birth item 16522 is the appropriate item for the management of fetal loss from 23 weeks.

CONSULTATIONS FOR PREGNANCY COMPLICATIONS

What are the new MBS items for pregnancy complications?

Two new items (16533 and 16534) covering attendances for pregnancy complications over 40 minutes will be introduced from 1 November 2017. The new items recognise that the pregnancy complications covered under existing items 16508 and 16509 can be complex and prolonged and a higher rebate of \$105.55 will be payable for attendances in-hospital which last at least 40 minutes.

New item 16533 covers attendances lasting at least 40 minutes for pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy.

New item 16534 covers attendances lasting at least 40 minutes for the treatment of pre-eclampsia, eclampsia or antepartum haemorrhage.

The new items are for in-hospital services only and can be claimed up to three times per pregnancy.



POSTNATAL CARE

What are the new MBS items for postnatal care?

New item for postnatal consultations – Item 16407

There will be a new item for a postnatal attendance between 4 and 8 weeks after birth (usually performed at 6 weeks after birth) performed by a GP or obstetrician, which can be claimed by patients who were admitted publicly or privately for the birth.

The new item will require a mental health assessment of the patient to be undertaken.

New item for postnatal home visit – Item 16408

The Medicare Benefits Schedule Review Taskforce Review of Obstetrics noted that the majority of women who give birth as a public patient in a public hospital receive at least one home visit in the week or two after birth from a state or local government employed midwife and/or child and maternal health nurse, but not all women who have a private obstetrician do.

The changes will introduce a new item for a postnatal home visit by an Obstetrician, GP or a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth) between 1 and 4 weeks following the birth, to enable private sector patients to access a postnatal home visit through Medicare.

EXTENDED MEDICARE SAFETY NET

What is the Extended Medicare Safety Net (EMSN) and EMSN benefit cap?

The EMSN provides an additional rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible out-of-hospital services.

The EMSN is not available for in-hospital services, or for services for which a Medicare rebate is not paid. Out-of-pocket costs for these services do not count towards the annual EMSN threshold. Once a person or registered family has met the relevant annual EMSN threshold in out-of-pocket costs, Medicare will pay 80 per cent of any future out-of-pocket costs for Medicare eligible out-of-hospital services for the remainder of the calendar year. The EMSN was introduced in March 2004.

The EMSN benefit cap is the maximum amount of EMSN benefits payable for an MBS item regardless of the fee charged by the doctor. EMSN caps were initially introduced on 1 January 2010.

Extended Medicare Safety Net caps apply to all relevant obstetric items. In total, an EMSN benefit cap applies to 569 MBS items to limit the amount the Government pays in safety net benefits.

Why is there an EMSN benefit cap?

The EMSN caps were introduced on 1 January 2010 following a review of the EMSN – which found the program had not reduced patient out-of-pocket costs and had led to a significant increase in MBS expenditure.

In response to this review, Parliament passed the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009 which introduced a power to cap the safety net benefits paid for certain items. The *Health Insurance (Extended Medicare Safety Net) Determination 2009* first introduced EMSN caps on 1 January 2010 for obstetrics, Assisted Reproductive Technology, hair transplantation for alopecia, one varicose vein item and cataract surgery.



In 2011, the Centre for Health Economics Research and Evaluation conducted an evaluation of the introduction of the EMSN caps. In response to the second review, capping was extended to a wider range of procedural items and an upper limit on the amount of EMSN benefits payable was introduced for all consultation items.

How do the new obstetrics caps compare to the existing obstetrics items?

The EMSN cap will be applied to the six new obstetrics items which commence from 1 November 2017. This is consistent with the arrangement for existing obstetrics services – which have been capped since 2010. Caps on existing obstetrics items will remain the same.

The new items will have an EMSN benefit cap of 65% of the schedule fee applied. The EMSN caps for new obstetrics items are provided below.

The six new obstetric items have a higher EMSN cap compared to existing caps on the majority of current obstetric items. This means that the Government will cover a higher proportion of out-of-pocket costs for the new items. A comparison of the obstetrics caps is at **Attachment 3**.

Item Number	Descriptor	Schedule fee	EMSN Cap
16407	<p>Postnatal professional attendance (other than a service to which any other item applies) if the attendance:</p> <ul style="list-style-type: none"> (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided <p>Payable once only for a pregnancy</p>	\$71.70	\$46.65 (65% of the schedule fee for this item)
16408	<p>Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:</p> <ul style="list-style-type: none"> (a) is by: <ul style="list-style-type: none"> (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided 	\$53.40	\$34.75 (65% of the schedule fee for this item)



	Payable once only for a pregnancy		
16530	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)	\$384.35	\$249.85 (65% of the schedule fee for this item)

Is this the change to the Medicare safety net which was proposed in the 2014-15 Budget?

No. That measure was in relation to the introduction of a single safety net. The Government reversed that measure in the 2017-18 Budget.

FURTHER INFORMATION

Factsheet: [Changes to MBS Items for Obstetrics Services](#)

Factsheet: [Medicare Safety Net Arrangements for New Obstetric Services](#)



ATTACHMENT 1

**MEDICARE BENEFITS SCHEDULE (MBS)
CHANGES TO OBSTETRIC ITEMS FROM 1 NOVEMBER 2017**

NOTE: The following tables show the changes to MBS Obstetrics items that will come into effect from 1 November 2017. In order to demonstrate the changes made to item descriptors, amended or added text has been highlighted in red; deletions are indicated in strikethrough text.

Item descriptors can be viewed or downloaded via the MBS Online website from 1 November 2017 at:
www.mbsonline.gov.au

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	<i>Group A3. Specialist Attendances to Which No Other Item Applies</i>
105	<p>Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies</p> <p>Fee: \$43.00 Benefit: 75% = \$32.25 85% = \$36.55</p> <p>Extended Medicare Safety Net Cap: \$129.00</p>

T4. OBSTETRICS	
	<i>Group T4. Obstetrics</i>
16401	<p>Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her—each attendance, other than a second or subsequent attendance in a single course of treatment, other than a service to which item 104 applies</p> <p>Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75</p> <p>Extended Medicare Safety Net Cap: \$54.90</p>
16406	<p>Antenatal professional attendance, as part of a single course of treatment, at 32–36 weeks of the patient’s pregnancy by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy</p> <p>Fee: \$133.95 Benefit: 75% = \$100.50 85% = \$113.90</p> <p>Extended Medicare Safety Net Cap: \$108.15</p>
16407 NEW ITEM	<p>Postnatal professional attendance (other than a service to which any other item applies) if the attendance:</p> <ul style="list-style-type: none"> (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and



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	<p>(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided</p> <p>Payable once only for a pregnancy</p> <p>Fee: \$71.70 Benefit: 75% = \$53.80 85% = \$60.95</p> <p>Extended Medicare Safety Net Cap: \$46.65</p>
16408 NEW ITEM	<p>Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:</p> <p>(a) is by:</p> <ul style="list-style-type: none"> (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and <p>(b) is between 1 week and 4 weeks after the birth; and</p> <p>(c) lasts at least 20 minutes; and</p> <p>(d) is for a patient who was privately admitted for the birth; and</p> <p>(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided</p> <p>Payable once only for a pregnancy</p> <p>Fee: \$53.40 Benefit: 85% = \$45.40</p> <p>Extended Medicare Safety Net Cap: \$34.75</p>
16508	<p>Pregnancy complicated by acute intercurrent infection, intra-uterine growth retardation fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each attendance each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day</p> <p>Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10</p> <p>Extended Medicare Safety Net Cap: \$22.00</p>
16509	<p>Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each attendance each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance</p> <p>Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10</p> <p>Extended Medicare Safety Net Cap: \$22.00</p>
16515	<p>Management of vaginal delivery birth as an independent procedure, if the patient’s care has been transferred by another medical practitioner for management of the delivery birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery birth (Anaes.)</p> <p>Fee: \$450.65 \$630.85 Benefit: 75% = \$338.00 \$473.15 85% = \$383.10 \$549.15</p> <p>Extended Medicare Safety Net Cap: \$175.60</p>
16518	<p>Management of labour, incomplete, if the patient’s care has been transferred to another medical practitioner for completion of the delivery birth (Anaes.)</p> <p>Fee: \$450.65 Benefit: 75% = \$338.00 85% = \$383.10</p>



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	Extended Medicare Safety Net Cap: \$175.60
16519	<p>Management of labour and delivery birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)</p> <p>Fee: \$693.95 Benefit: 75% = \$520.50 85% = \$613.75</p> <p>Extended Medicare Safety Net Cap: \$329.15</p>
16520	<p>Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)</p> <p>Fee: \$811.05 \$630.85 Benefit: 75% = \$608.30 \$473.15 85% = \$730.85 \$549.15</p> <p>Extended Medicare Safety Net Cap: \$329.15</p>
16522	<p>Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days:</p> <ul style="list-style-type: none"> (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: <ul style="list-style-type: none"> (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: <ul style="list-style-type: none"> (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: <ul style="list-style-type: none"> (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: <ul style="list-style-type: none"> (i) at least 2+ proteinuria on urinalysis; or



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(ii) protein-creatinine ratio greater than 30 mg/mmol; or

(iii) platelet count less than 150 x 10⁹/L; or

(iv) uric acid greater than 0.36 mmol/L;

(l) gestational diabetes mellitus requiring at least daily blood glucose monitoring;

(m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:

(i) the patient requiring hospitalisation; or

(ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or

(iii) the patient having a GP mental health treatment plan; or

(iv) the patient having a management plan prepared in accordance with item 291;

(n) disclosure or evidence of domestic violence;

(o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:

(i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;

(ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);

(iii) previous renal or liver transplant;

(iv) renal dialysis;

(v) chronic liver disease with documented oesophageal varices;

(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);

(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;

(viii) maternal height of less than 148 cm;

(ix) a body mass index greater than or equal to 40;

(x) pre-existing diabetes mellitus on medication prior to pregnancy;

(xi) thyrotoxicosis requiring medication;

(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;

(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;

(xiv) HIV, hepatitis B or hepatitis C carrier status positive;

(xv) red cell or platelet iso-immunisation;

(xvi) cancer with metastatic disease;

(xvii) illicit drug misuse during pregnancy

(H) (Anaes.)

Fee: \$1,629.35 **Benefit:** 75% = \$1222.05 ~~85% = \$1549.15~~

Extended Medicare Safety Net Cap: ~~\$438.90~~-N/A

16525

MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross



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	<p>fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.)</p> <p>Fee: \$384.35 Benefit: 75% = \$288.30—85% = \$326.70</p> <p>Extended Medicare Safety Net Cap: \$153.70</p>
16527	<p>Management of vaginal delivery-birth, if the patient's care has been transferred by a participating midwife for management of the delivery-birth, including all attendances related to the delivery-birth (Anaes.)</p> <p>Payable only once for a pregnancy</p> <p>Fee: \$450.65 \$630.85 Benefit: 75% = \$338.00 \$473.15 85% = \$383.10 \$549.15</p> <p>Extended Medicare Safety Net Cap: \$175.60</p>
16528	<p>CAESAREAN SECTION and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.)</p> <p>(See para TN.4.8 of explanatory notes to this Category)</p> <p>Fee: \$811.05 \$630.85 Benefit: 75% = \$608.30 \$473.15 85% = \$730.85 \$549.15</p> <p>Extended Medicare Safety Net Cap: \$329.15</p>
16530 NEW ITEM	<p>Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)</p> <p>Fee: \$384.35 Benefit: 75% = \$288.30 85% = \$326.70</p>
16531 NEW ITEM	<p>Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.) (H)</p> <p>Fee: \$768.70 Benefit: 75% = \$576.55</p>
16533 NEW ITEM	<p>Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (H)</p> <p>Fee: \$105.55 Benefit: 75% = \$79.20</p>
16534 NEW ITEM	<p>Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (H)</p> <p>Fee: \$105.55 Benefit: 75% = \$79.20</p>
16590	<p>Planning and management, by a practitioner, of a pregnancy if:</p> <p>(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and</p> <p>(b) the patient intends to be privately admitted for the birth; and</p> <p>(c) the pregnancy has progressed beyond 28 weeks gestation; and</p>



T4. OBSTETRICS	
	<p>(d) the practitioner has maternity privileges at a hospital or birth centre; and</p> <p>(e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and</p> <p>(f) a service to which item 16591 applies is not provided in relation to the same pregnancy</p> <p>Payable once only for a pregnancy</p> <p>Fee: \$324.10 \$372.75 Benefit: 75% = \$243.10 \$279.60 85% = \$275.50 \$316.85</p> <p>Extended Medicare Safety Net Cap: \$219.45</p>
16591	<p>Planning and management, by a practitioner, of a pregnancy if:</p> <p>(a) the pregnancy has progressed beyond 28 weeks gestation; and</p> <p>(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and</p> <p>(c) a service to which item 16590 applies is not provided in relation to the same pregnancy</p> <p>Payable once only for a pregnancy</p> <p>Fee: \$142.65 Benefit: 75% = \$107.00 85% = \$121.30</p> <p>Extended Medicare Safety Net Cap: \$109.75</p>
16606	<p>Fetal blood sampling, using interventional techniques from umbilical cord or foetus fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)</p> <p>Fee: \$243.25 Benefit: 75% = \$182.45 85% = \$206.80</p> <p>Extended Medicare Safety Net Cap: \$131.75</p>
16633	<p>PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627</p> <p>Derived Fee: 50% of the fee for the first foetus for any additional foetus tested</p> <p>Extended Medicare Safety Net Cap: \$230.50</p>
16636	<p>PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624</p> <p>Derived Fee: 50% of the fee for the first foetus for any additional foetus tested</p> <p>Extended Medicare Safety Net Cap: \$87.85</p>

MEDICARE BENEFITS SCHEDULE (MBS) CONSEQUENTIAL CHANGES FROM 1 NOVEMBER 2017

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA	
	<p><i>Group T10: Relative Value Guide for Anaesthesia – Medicare Benefits are Only Payable for Anaesthesia Performed in Association with an Eligible Service</i></p>



T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA

20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of delivery birth Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45
20946	Initiation of the management of anaesthesia for vaginal delivery birth Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65
20958	Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery birth Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15

T9 – ASSISTANCE AT OPERATIONS

	<i>Group T9: Assistance at Operations</i>
51306	Assistance at a delivery birth involving Caesarean section Fee: \$124.65 Benefit: 75% = \$93.50 85% = \$106.00
51309	Assistance at a series or combination of operations that include “(Assist.)” and assistance at a delivery birth involving Caesarean section Derived Fee: One fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 16615 and 16627 Derived Fee: One fifth of the established fee for the procedure or combination of procedures



Attachment 2

CHANGES TO MBS EXPLANATORY NOTES FOR OBSTETRICS
ITEMS FROM 1 NOVEMBER 2017

Number	Explanatory Note
<p>TN.4.2 Amended note</p>	<p>Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)</p> <p>16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. Item 16500 is still claimed for routine antenatal attendances. These items are subject to Extended Medicare Safety Net caps.</p> <p>Item links: 16401, 16404</p>
<p>TN.4.3 Amended note</p>	<p>Antenatal Care - (Item 16500)</p> <p>In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-</p> <p>(a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.</p> <p>(b) The initial consultation at which pregnancy is diagnosed.</p> <p>(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.</p> <p>(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.</p> <p>(e) Treatment of an intercurrent condition not directly related to the pregnancy.</p> <p>Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and birth.</p> <p>Item links: 16500, 16501, 16502, 16505, 16508, 16509, 16511, 16512, 16514, 16600, 16603, 16606, 16609, 16612, 16615, 16618, 16621, 16624, 16627, 16533, 16534</p>
<p>TN.4.4 Amended note</p>	<p>External Cephalic Version for Breech Presentation - (Item 16501)</p> <p>Contraindications for this item are as follows:</p> <ul style="list-style-type: none"> - antepartum haemorrhage (APH) - multiple pregnancy, - fetal anomaly, - fetal growth restriction, - caesarean section scar,



	<ul style="list-style-type: none"> - uterine anomalies, - obvious cephalopelvic disproportion, - isoimmunization, - premature rupture of the membranes. <p>Item links: 16501</p>
<p>TN.4.5 Amended note</p>	<p>Labour and Birth - (Items 16515, 16518, 16519, 16530 and 16531)</p> <p>Benefits for management of labour and birth covered by Items 16515, 16518, 16519, 16530 and 16531 includes the following (where indicated):-</p> <ul style="list-style-type: none"> - surgical and/or intravenous infusion induction of labour; - forceps or vacuum extraction; - evacuation of products of conception by manual removal (not being an independent procedure); - episiotomy or repair of tears. <p>Item 16519 covers birth by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of birth by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.</p> <p>In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.</p> <p>Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.</p> <p>Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal birth) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and birth, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.</p> <p>At a high risk birth benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the birth) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk births include cases of difficult vaginal birth, Caesarean section or the birth of babies with Rh problems and babies of toxæmic mothers.</p> <p>Item links: 16515, 16518, 16519, 16530, 16531</p>
<p>TN.4.6 Amended note</p>	<p>Caesarean Section - (Item 16520)</p> <p>Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the birth by Caesarean</p>



	<p>section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.</p> <p>Item links: 16519, 16520</p>
TN.4.7 Amended note	<p>Complicated Confinement - (Item 16522)</p> <p>A record of the clinical indication/s that constitute billing under item 16522 should be retained on the patient's medical record.</p> <p>Item links: 16522</p>
TN.4.8 Amended note	<p>Labour and Birth Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)</p> <p>Where the intrapartum care of a patient is transferred to a medical practitioner by a participating midwife for the management of birth, item 16527 or 16528 would apply depending on the service provided.</p> <p>Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.</p> <p>Item links: 16527, 16528</p>
TN.4.9 Amended note	<p>Items for Planning and Management of a Pregnancy (Item 16590 and 16591)</p> <p>Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 28 weeks, where the medical practitioner is intending to undertake the birth for a privately admitted patient.</p> <p>Item 16591 is for the planning and management of a pregnancy that has progressed beyond 28 weeks and the medical practitioner is providing shared antenatal care and is not intending to undertake the birth.</p> <p>Items 16590 and 16591 are to include the provision of a mental health assessment of the patient. Both items are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.</p> <p>Item links: 16590, 16591</p>
TN.4.10 Amended note	<p>Post-Partum Care - (Items 16515 to 16520 and 16564 to 16573)</p> <p>The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-</p> <p>(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;</p> <p>(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);</p> <p>(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for</p>



	<p>benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <u>while in labour</u> from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the birth;</p> <p>(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;</p> <p>(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.</p> <p>Normal postnatal care by a medical practitioner would include:-</p> <p>(i) uncomplicated care and check of</p> <ul style="list-style-type: none"> - lochia - fundus - perineum and vulva/episiotomy site - temperature - bladder/urination - bowels <p>(ii) advice and support for establishment of breast feeding</p> <p>(iii) psychological assessment and support</p> <p>(iv) Rhesus status</p> <p>(v) Rubella status and immunisation</p> <p>(vi) contraception advice/management</p> <p>Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits</p> <p>Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal birth. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.</p> <p>Item links: 16515, 16519, 16520, 16564, 16567, 16570, 16571, 16573, 16518</p>
<p>TN.4.11 Amended note</p>	<p>Interventional Techniques - (Items 16600 to 16627, 35518 and 35674)</p> <p>For Items 16600 to 16627, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.</p> <p>Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, and 16627.</p> <p>Item links: 16600, 16603, 16606, 16609, 16612, 16615, 16618, 16621, 16624, 16627, 51312,</p>



	35518, 35674
TN.9.4 Amended note	Benefits Payable Under Item 51309 Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section. Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306. Item links: 51309
TN.4.13 New note	Mental Health Assessments for Obstetric Patients (Items 16590, 16591, 16407) Items for the planning and management of pregnancy (16590 and 16591) and for a postnatal attendance between 4 and 8 weeks after birth (16407), include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence, to be performed by the clinician or another suitably qualified health professional on behalf of the clinician. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a rebate being payable for these items. It is recommended that mental health assessments associated with items 16590, 16591, and 16407 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: <i>Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline – October 2017</i> , Centre for Perinatal Excellence. Results of the mental health assessment must be recorded in the patient's medical record. A record of a patient's decision not to undergo a mental health assessment must be recorded in the patient's clinical notes. Item links: 16590, 16591, 16407
TN.4.14 New note	Extended Medicare Safety Net (EMSN) for Obstetric Services (Items 16531, 16533 and 16534) The Extended Medicare Safety Net (EMSN) benefit is capped at 65% of the schedule fee for obstetric items 16531, 16533, and 16534. However, as these items are for in-hospital services only, the EMSN does not apply Item links: 16531, 16534, 16533



ATTACHMENT 3

OBSTETRIC EMSN BENEFIT CAP COMPARISON TABLE

Item	Schedule fee	EMSN cap	% EMSN cap	Lower than 65% cap	Item Description
Current MBS Obstetric items					
16399	Derived	\$24.10			Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the act applies
16400	\$27.25	\$11.05	40.6%	yes	Antenatal service provided by a midwife, nurse or an aboriginal and torres strait islander health practitioner if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area rma 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy
16401	\$85.55	\$54.90	64.2%	yes	Obstetric specialist, referred consultation - surgery or hospital professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each initial attendance, in a single course of treatment - not being a service to which item 104 applies.
16404	\$43.00	\$32.95	76.6%	no	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance subsequent to the first attendance in a single course of treatment.
16406	\$133.95	\$108.15	80.7%	no	32-36 week obstetric visitantenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient’s pregnancy when the patient is referred by a participating midwife. payable only once for a pregnancy.
16500	\$47.15	\$32.95	69.9%	no	Antenatal attendance
16501	\$140.55	\$65.90	46.9%	yes	External cephalic version for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version ctg, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ecv's per pregnancy
16502	\$47.15	\$22.00	46.7%	yes	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day



16505	\$47.15	\$22.00	46.7%	yes	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
16508	\$47.15	\$22.00	46.7%	yes	Pregnancy complicated by acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day
16509	\$47.15	\$22.00	46.7%	yes	Preeclampsia, eclampsia or antepartum haemorrhage, treatment of each attendance that is not a routine antenatal attendance
16511	\$219.95	\$109.75	49.9%	yes	Cervix, purse string ligation of (Anaes.)
16512	\$63.50	\$32.95	51.9%	yes	Cervix, removal of purse string ligature of (Anaes.)
16514	\$36.65	\$16.55	45.2%	yes	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)
16515	\$450.65	\$175.60	39.0%	yes	Management of vaginal delivery as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.)
16518	\$450.65	\$175.60	39.0%	yes	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.)
16519	\$693.95	\$329.15	47.4%	yes	Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)
16520	\$811.05	\$329.15	40.6%	yes	Caesarean section and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)
16522	\$1,629.35	\$438.90	26.9%	yes	Management of labour and delivery, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management one, or more, of the following conditions is present, including postnatal care for 7 days: . multiple pregnancy; recurrent antepartum haemorrhage from 20 weeks gestation; grades 2, 3 or 4 placenta praevia; baby with a birth weight less than or equal to 2500gm; pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; . trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; or . conditions that pose a significant risk of maternal death. (Anaes.)
16525	\$384.35	\$153.70	40.0%	yes	Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.)
16527	\$450.65	\$175.60	39.0%	yes	Management of vaginal delivery, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. payable once only for a pregnancy. (Anaes.)
16528	\$811.05	\$329.15	40.6%	yes	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating



					midwife for management of the birth. payable once only for a pregnancy. (Anaes.)
16564	\$218.00	\$219.45	100.7%	no	Evacuation of retained products of conception (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)
16567	\$318.80	\$219.45	68.8%	no	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.)
16570	\$416.05	\$219.45	52.7%	yes	Acute inversion of the uterus, vaginal correction of, as an independent procedure (Anaes.)
16571	\$318.80	\$219.45	68.8%	no	Cervix, repair of extensive laceration or lacerations (Anaes.)
16573	\$259.80	\$219.45	84.5%	no	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)
16590	\$324.10	\$219.45	67.7%	no	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies.
16591	\$142.65	\$109.75	76.9%	no	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies.
16600	\$63.50	\$32.95	51.9%	yes	Amniocentesis, diagnostic
16603	\$121.85	\$65.90	54.1%	yes	Chorionic villus sampling, by any route
16606	\$243.25	\$131.75	54.2%	yes	Foetal blood sampling, using interventional techniques from umbilical cord or foetus, including foetal neuromuscular blockade and amniocentesis (Anaes.)
16609	\$496.00	\$252.40	50.9%	yes	Foetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)
16612	\$390.25	uncapped		yes	Foetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)
16615	\$207.85	uncapped		yes	Foetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)
16618	\$207.85	\$104.30	50.2%	yes	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500ml being aspirated
16621	\$207.85	uncapped		yes	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios
16624	\$299.10	\$142.65	47.7%	yes	Foetal fluid filled cavity, drainage of
16627	\$608.95	\$307.25	50.5%	yes	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis
16633	Derived	\$230.50		yes	Procedure on multiple pregnancies relating to items 16606, 16609, 16612, 16615 and 16627
16636	Derived	\$87.85		yes	Procedure on multiple pregnancies relating to items 16600, 16603, 16618, 16621 and 16624



New MBS Obstetric items				
16407	\$71.70	\$46.65	65%	Postnatal professional attendance (other than a service to which any other item applies) if the attendance: (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided - Payable once only for a pregnancy
16408	\$53.40	\$34.75	65%	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:(a) is by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided - Payable once only for a pregnancy
16530	\$384.35	\$249.85	65%	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)
16531	\$768.70	\$499.70	65%	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.) (H)
16533	\$105.55	\$68.65	65%	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (H)
16534	\$105.55	\$68.65	65%	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (H)