Commonwealth Department of
Health and
Aged Care

Supplement to Medicare Benefits Schedule book of

1 November 1999

EFFECTIVE 1 MAY 2000

Supplement to the

Medicare Benefits Schedule Book

Of 1 November 1999

Effective 1 May 2000

Commonwealth Department of Health and Aged Care

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This book provides information on the arrangements for the payment of Medicare benefits for professional services rendered by registered medical practitioners and approved dental practitioners (oral surgeons). These arrangements operate under the Health Insurance Act 1973 (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

SUPPLEMENT TO 1 NOVEMBER 1999 MEDICARE BENEFITS SCHEDULE BOOK

AMENDMENTS EFFECTIVE 1 MAY 2000

This supplement provides details of changes to the 1 November 1999 edition of the Medicare Benefits Schedule book. Any item not included in this supplement remains as it is shown in the 1 November 1999 Schedule book.

At the time of printing, the relevant legislation giving authority for the changes included in this supplement may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny.

SAFETY NET

The Medicare "safety net" increased to $285.00 with effect from 1 January 2000 (see para 1.1 of General Explanatory Notes to the 1 November 1999 Medicare Benefits Schedule book for details of the safety net).

INCREASE IN FEES FOR GENERAL PRACTITIONER ATTENDANCES

Schedule fees for a range of general practice non-referred attendance items (excluding EPC) will increase by an average of 2.27% from 1 May 2000, reflecting the management of benefit payments for these items under the General Practice Memorandum of Understanding (GP MoU). This increase is to ensure that the GP rebate payments meet the three year guaranteed minimum MBS outlays target agreed to in the GP MoU.

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Audiometry** – new item for oto-acoustic emission audiometry (Item 11332) (see note below)
- **Therapeutic nuclear medicine** – new listing for ^{153}Sm-lexidronam therapy for relief of bone pain (Item 16018) (see note below)
- **General surgery** – amendment to Items 30219 and 30222G/30223S covering incision of haematoma, with deletion of general practitioner/specialist fee differential
- **Breast surgery** – revised item structure (Items 30332 to 30372)
- **Plastic surgery** – new items (45496 to 45499) for revision of previous flap repair
- **Burns surgery** – new item structure for conjoint surgery (Items 45460 to 45484)
- **Orthopaedic surgery** – new items for knee surgery (49564) and foot surgery (49837, 49838)

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.

MEDICARE BENEFITS FOR ^{153}SM-LEXIDRONAM THERAPY FOR RELIEF OF BONE PAIN

Following a recommendation of the Medicare Services Advisory Committee, a new item for ^{153}Sm-lexidronam therapy for relief of bone pain due to skeletal metastases from carcinoma of the breast or prostate (Item 16018) was introduced into the Schedule via Ministerial Determination under section 3C of the Health Insurance Act (effective 22 December 1999).

This item has now been transferred to the Regulations with effect from 1 May 2000.

MINISTERIAL DETERMINATION – ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM

Following a recommendation of the Medicare Services Advisory Committee, two new items (33116 and 33119) were introduced into the Schedule from 1 November 1999 via Ministerial determination under section 3C of the Health Insurance Act. Payment of Medicare benefits was dependent on the submission of data to the Health Insurance Commission to assist in the assessment of the long-term safety and effectiveness of the procedure.

This arrangement has now been revised, in consultation with the Royal Australasian College of Surgeons (RACS), and the payment of Medicare benefits is no longer dependent on the provision of clinical data to the Commission. However, benefits will continue to be provided on an interim basis only, with the continuation of funding conditional on a 95% compliance rate with quality assurance activities implemented by RACS. The matter will be reviewed in 12 months.

The revised arrangement applies from 22 December 1999.

PROPOSED SURGERY – ASSESSMENT OF BENEFITS PAYABLE

For those items in the Schedule which contain a requirement that it must be 'demonstrated' that there is a clinical need for the service before Medicare benefits are payable, practitioners may apply for prospective approval in respect of proposed surgery.

Appropriate clinical and/or photographic evidence to enable the Health Insurance Commission to determine the eligibility of the service for benefits should be submitted in the usual manner.

OBSTETRICS ANTENATAL CARE (Items 16502 to 16508)

The Schedule fees for Items 16502, 16504, 16505 and 16508 have been increased from $25.65 to $25.85 to realign their fees with Items 16500 and 16509.

LENS SURGERY (Items 42698, 42701 and 42702)

It is not intended that these items be used for the correction of refractive error only.

THE PROFESSIONAL SERVICES REVIEW (PSR) SCHEME
HIGH VOLUME SERVICING

On 1 January 2000, new Regulations commenced which provide that where a practitioner reaches or exceeds a prescribed pattern of services, he or she is deemed to have practised inappropriately for the purposes of the Professional Services Review (PSR) Scheme.

The pattern of services for general practitioners and other medical practitioners specified in the Regulations is 80 or more professional attendances on each of 20 or more days in a 12-month period.

- A professional attendance is defined as a service of a kind mentioned in group A1, A2, A5, A6, A7, A13, A14 or A15 of Part 2 of the General Medical Services Table.

The quantum of inappropriate practice can be reduced if the practitioner can demonstrate exceptional circumstances to the satisfaction of a PSR Committee. Matters that constitute exceptional circumstances include, but are not limited to, those set out in the Regulations. Matters constituting exceptional circumstances, as set out in the regulations, are: an usual occurrence causing an unusual level of need for professional attendances by the practitioner; and the absence of other medical services for the practitioner's patients (having regard to the location of the practice and the characteristics of the patients).

Where a practitioner can demonstrate to the satisfaction of a PSR Committee that exceptional circumstances exist, the quantum of inappropriate practice is reduced accordingly. For example, a general practitioner is referred to a PSR Committee for rendering more than 80 services on 28 days in a 12-month period. The practitioner demonstrates to the PSR Committee that exceptional circumstances applied on 10 of those days. The practitioner would still be found to have engaged in inappropriate practice in respect of the remaining 18 days.

ENHANCED PRIMARY CARE AND THE NEW MBS ITEMS
(HEALTH ASSESSMENTS, CARE PLANS AND CASE CONFERENCES)

CATEGORY 1 – PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

***Please note**: Amendments have been made to the following Enhanced Primary Care explanatory notes. Changes have been identified by italicised bolding and the use of underlining identifies where text has been moved from other areas within the explanatory notes.*

A.20 Health Assessments (Items 700 to 706)

A.20.1 These items do not apply to in-patients of a hospital or day hospital facility, or residents of a nursing home.

A.20.2 The information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components of the health assessment must include a personal attendance by the medical practitioner.

A.20.3 For items 704 and 706, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent. Patients should be asked to self-identify their Indigenous status and state their age for the purposes of these items, either verbally or by completing a form. Difficulties may arise in relation to establishing the age of the patient. Knowledge of a person's age or date of birth is sometimes considered irrelevant by Indigenous people and as such some people may not be able to answer with a high degree of accuracy.

A.20.4 A health ***assessment*** means the assessment of a patient's health and physical, psychological and social function and whether preventative health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A.20.5 ***The assessment must include***:

(a) measurement of the patient's blood pressure, pulse rate and rhythm; and
(b) an assessment of the patient's medication; and
(c) an assessment of the patient's continence; and
(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
(e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months; and
(f) an assessment of the patient's psychological function, including the patient's cognition and mood; and
(g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

A.20.6 The assessment must also include keeping a record of the health assessment, signed by the patient and giving the patient a written report about the health assessment, with recommendations about matters covered by the health assessment.

A.20.7 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include category 5 (diagnostic imaging) services or category 6 (pathology) services. (See General Notes 13.3.)

A.20.8 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.

A.20.9 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.20.10 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home the latter item should be claimed.

A.20.11 The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should consider the following:

Medical:

Medication review

This should include a review of medications taken including OTCs and prescriptions from other doctors; medications prescribed but not taken; interactions; and review of indications. In this age group, side effects and interactions occur more frequently and at lower dosage than in younger adults.

Blood pressure and pulse rate and rhythm

Where the assessment identifies a spot high blood pressure reading or evidence of atrial fibrillation (irregularly irregular pulse), a follow up consultation should be arranged to determine further management.

Continence

Continence problems are under reported and a major cause of reduced quality of life in this age group. They are usually easily detectable by direct questioning, and when first diagnosed are frequently amenable to improved management. If identified, a follow up consultation should be arranged to investigate the underlying pathology and arrange management.

Immunisation status (Influenza, Tetanus, Pneumococcus)

The NH&MRC recommends the following vaccination schedule for this age group:

- Tetanus toxoid OR Combined ***Diphtheria*** and Tetanus vaccine - every 10 years;
- Influenza vaccine - annually; and
- Pneumococcal vaccine - every 5 years.

Physical function:

Activities of Daily Living

Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. As a minimum, the patient's ability to transfer between bed, chair and toilet, bathe, dress, prepare food and eat should be assessed. The assessment should also include whether the patient can: use the telephone; get to the shops or the bank; read books; watch TV; listen to the radio or recorded music; and look after the house (cleaning, minor repairs etc).

Where significant functional impairment is identified, the use of a formal instrument such as the Index of Independence in Activities of Daily Living; the Modified Barthel Index; or the Medical Outcome Study Physical Functioning Measure should be considered.

Falls in last 3 months

The patient should be asked whether they have suffered any falls in the previous three months. A recent fall is the strongest predictor of future fall related injury.

Psychological function:

Cognition

Unrecognised dementia is common in this age group. Detailed diagnosis can often improve quality of life. Cognition ***can be*** assessed with a recognised tool such as the Folstein Mini Mental State Examination or the Hodkinson Abbreviated Mental Assessment.

Mood

At a minimum, the assessment should include enquires about depressed affect. If mental symptoms are present (eg abnormal affect or memory loss), the use of a formal depression scale such as the Geriatric Depression Scale should be considered.

Social function:

Availability and adequacy of paid and unpaid help when needed and wanted

This is the central component of an assessment of the patient's social support. People's social networks tend to become smaller as they age, and the role of formal services may need to increase correspondingly.

Caring for another person
Being a carer for another person can significantly affect physical and psychological health and substantially reduce opportunities to maintain social networks. When the person being assessed is a carer, the assessment should include: an evaluation of the effect of this role on health and functioning; and the provision of information about local carer support services, including regular or emergency respite care.

NB: The tools referred to in the preceding explanatory notes should be used at the clinical discretion of the practitioner and practitioners using such tools should be familiar with their use and if not, should seek appropriate education/training.

A.20.12 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use.

A.21 Care Planning (Items 720 to 728)

A.21.1 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital or day hospital facility, or a resident of a nursing home.

A.21.2 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility, and is not a resident of a nursing home.

*Preparation of a **community** care plan or a discharge care plan*
A.21.3 For items 720, 722, 724, 726 and 728, preparation of a multidisciplinary care plan means the preparation of a written plan describing the following matters:
(a) an assessment of the ***patient and their*** health care needs; ***and***
(b) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; ***and***
(c) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services providers); and
(d) arrangements for giving the treatment, services and care referred to in paragraph (b); ***and***
(e) management goals with which the patient agrees; ***and***
(f) arrangements to review the plan by a day specified in the plan.

A.21.4 Preparation of the plan must also include:
(a) ***a meeting with the patient to discuss the preparation of the plan***; and
(b) telling the patient who will be included in the multidisciplinary care plan team; and
(c) recording the plan and the patient's agreement to the preparation of the plan; and
(d) giving copies of relevant parts of the plan to persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
(e) giving a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient; and
(f) if the patient is eligible to be provided with treatment under Part V of the *Veterans' Entitlement Act 1986*, giving a copy of the plan to the Department of Veterans' Affairs.

A.21.5 A multidisciplinary care plan team includes a medical practitioner and at least 2 other members who contribute to the plan, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner ***(normally a specialist or consultant physician).***

Example
Examples of persons who, for paragraph (b), may be included in a team are allied health professions such as: Aboriginal health care workers; audiologists; dental therapists; dentists; dieticians; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient's informal carer is not counted toward the minimum of three.

A.21.6 In making arrangements for implementation of the plan, the medical practitioner should ascertain the availability of care from other providers. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a telephone conversation.

A.21.7 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while formal documentation is prepared and members of the multidisciplinary care plan team are contacted.

A.21.8 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service ***provided by the practitioner*** for which a Medicare rebate will be payable;
- ***Inform the patient of any additional costs he or she will incur.***

A.21.9 While no standard format for the care plan is mandated, practitioners should consider a recognised care planning tool, for example ***those developed by the Royal Australian College of General Practitioners (RACGP).***

A.21.10 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if the patient's clinical condition has changed markedly since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 ***(see paragraphs A.21.14 and A.21.15).***

A.21.11 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

Discharge care plans

A.21.12 For items 722 and 728 a multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient before the patient is discharged from a hospital.

A.21.13 Preparation of a discharge care plan (item 722) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Review of care plans

A.21.14 For item 724, review of a multidisciplinary care plan means a process by which the medical practitioner ***who prepared the care plan***:

(a) ***reviews a community care plan or discharge care plan prepared under item 720 or 722 including reviewing the matters mentioned in A.21.3***; and
(b) considers whether the arrangements for treatment, service and care have been carried out; and
(c) ***consults with other members of the multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan***; and
(d) if different arrangements need to be made, prepares a revised multidisciplinary care plan, stating those arrangements.

A.21.15 The review of the plan must also include:

(a) discussing the review of the plan with the patient; and
(b) recording the patient's agreement to reviewing the plan; and
(c) giving copies of relevant parts of the revised multidisciplinary care plan (if any) to the patient, and to persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan; and
(d) if the patient holds an entitlement for treatment under Part V of the *Veterans' Entitlements Act 1986*, giving a copy of the revised multidisciplinary care plan (if any) to the Department of Veterans' Affairs.

Contribution to care plans

A.21.16 For items 726 and 728, a contribution to a multidisciplinary ***community*** care plan or a multidisciplinary discharge care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.17 Contribution to a plan does not include preparation of a multidisciplinary ***community*** care plan or a multidisciplinary discharge care plan, ***but can include contribution to a review of a care plan organised by another provider.***

A.21.18 It is expected that the medical practitioner's contribution to a ***community*** care plan or a discharge plan would take at least 10 minutes and can be made by either face-to-face meeting, telephone, fax, e-mail, written correspondence or other means.

A.21.19 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.20 Before commencing a care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.21 Contribution to a discharge care plan can be for either a private or public in-patient and the contribution must be made by the patient's usual medical practitioner.

A.21.22 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes 7.6).

A.22 Case Conferences (Items 740 to 773)

A.22.1 Items 740, 742, 744, 759, 762 and 765 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital or day hospital facility, or a resident of a nursing home.

A.22.2 Items 746, 749, 757, 768, 771 and 773 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility and is not a resident of a nursing home.

A.22.3 A case conference is a process by which a case conference team carries out the following activities:

(a) discussing a patient's history; and
(b) identifying the patient's multidisciplinary care needs; and
(c) identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
(d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
(e) assessing whether previously identified outcomes (if any) have been achieved.

A.22.4 For items 746, 749, 757, 768, 771 and 773, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility.

A.22.5 A case conference team includes a medical practitioner and at least 2 other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner ***(normally a specialist or consultant physician).***

Example

Examples of persons who, for paragraph (c), may be included in a team are allied health professionals such as: Aboriginal health care workers; audiologists; dental therapists; dentists; dieticians; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient or his or her informal carer is not counted toward the minimum of three.

Organisation of a community case conference or a discharge case conference

A.22.6 For items 740, 742, 744, 746, 749 and 757, organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and

(b) recording the patient's agreement to the case conference; and

(c) recording the day on which the conference was held, and the times at which the conference started and ended; and

(d) recording the names of the participants; and

(e) recording the matters mentioned in A.22.3 and putting a copy of that record in the patient's medical records; and

(f) giving the patient, and each other member of the team a summary of the conference; ***and***

(g) discussing the outcomes of the case conference with the patient.

A.22.7 Organisation of a discharge case conference (items 746, 749 and 757), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Participation in case conference

A.22.8 For items 759, 762, 765, 768, 771 and 773, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) explaining to the patient the nature of a case conference, and asking the patient whether he or she agrees to the medical practitioner participating in the case conference; and

(b) recording the patient's agreement to the medical practitioner participating in the case conference; and

(c) recording the day on which the conference was held, and the times at which the conference started and ended; and

(d) recording the names of the participants; and

(e) recording the matters mentioned in A.22.3 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records; and

(f) giving the patient a summary of the conference.

Items 768, 771 and 773 can be claimed by either private or public in-patients.

General requirements

A.22.9 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.22.10 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.22.11 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and

- Inform the patient that he or she will incur a charge for the service ***provided by the practitioner*** for which a Medicare rebate will be payable.
- ***Inform the patient of any additional costs he or she will incur.***

A.22.12 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

DIAGNOSTIC IMAGING SERVICES (EFFECTIVE 1 MAY 2000)

DIH.9 Ultrasound Scan of Pelvis or Abdomen, pregnancy related – Item 55728

This item should only be utilised in situations where a patient with a clinical condition not listed in Items 55718, 55721, 55723 and 55725 requires a post 22 week ultrasound. Claims for this item are required to be assessed by the Health Insurance Commission on an individual basis and should be accompanied by details of the clinical basis for the service. The claim and the additional information should be lodged with Medicare in the usual manner and sealed in an envelope marked 'Medical-in-Confidence'.

DIH.10 Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721 and 55728)

In relation to items 55712, 55721 and 55728, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999)

Computerised Tomography Item renumbering (56033 and 56039)

Items 56033 and 56039 have been renumbered to 56070 and 56076 respectively, in order to be consistent with other CT items.

PATHOLOGY SERVICES (EFFECTIVE 1 MAY 2000)

A restructure of haematology Items 65132, 65138 and 65141 with the introduction of a number of new haematology items now ensures a more logical testing algorithm in venous thromboembolic disease (thrombophilia). The new items include a test for the confirmation of results following initial testing for thrombophilia, a genetic test for the characterisation of the genotype of patients for Factor V Leiden gene mutation and other relevant mutations known to be associated with venous thrombosis, and a genetic test for first degree relatives of patients who have been proven to have the Factor V Leiden gene mutation or other relevant mutations associated with venous thrombosis. The new testing algorithm will further assist in the identification of patients at higher risk of thrombosis who may benefit from prevention and improved treatment strategies.

Other amendments to the Table include a change to the number of blood glucose measurements required for the oral glucose tolerance test item from 3 measurements to 2 measurements (Item 66542), an amendment to microbiology Item 69324 to accurately reflect the intent of the item and a minor change to microbiology Item 69336 to ensure consistency with other related items by inclusion of 'in any 7 day period'. Cytology Items 73049 and 73051 have been slightly amended to include 'Cytology of material' to remove ambiguity in the item descriptors.

A change has also been made to the histopathology complexity levels with the addition of a new specimen type entry for skin, eyelid, wedge resection.

SUMMARY OF CHANGES

The 1 May 2000 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

(a)	new item	†
(b)	description amended	‡
(c)	fee amended	+
(d)	anaesthetics amended	@
(e)	item number change	*
(f)	addition/deletion (Assist.)	A
(g)	new item (previous Ministerial Determination)	▲

New Items

11332 16018 30335 30336 30339 30340 30343 30344 30347 30348 30351 30352 30354 30355 45460 45461
45462 45464 45465 45466 45468 45469 45471 45472 45474 45475 45477 45478 45480 45481 45483 45484
45496 45497 45498 45499 49564 49837 49838 65133 65134 65135 65136 65137 65139 65140 65142 65168
65171 65174

Deleted Items

30222 30333 30337 30338 30341 30342 30345 30346 30349 30350 30353 30356 30359 45419 65138 65141

Amended Description

720 724 726 728 740 742 744 759 762 765 30219 30223 30332 30360 30364 49827
49830 55712 55721 55728 65132 66542 69324 69336 73049 73051

Amended Fees

1 2 3 4 13 19 20 23 24 25 33 35 36 37 38 40
43 44 47 48 50 51 160 161 162 163 164 193 195 601 602 16502
16504 16505 16508 30332 30360 30364 30366 30367 30369 30370 30372 65132 66542

Item Number Change

Old	New
56033	56070
56039	56076

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where the description, item number or Schedule fee for an item has been amended the following rule will apply:-

If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 2000 and continues beyond that date, the old (1 November 1999) item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A NURSING HOME, HOSPITAL, INSTITUTION OR HOME

	LEVEL A			LEVEL B		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	31.35	26.65	23.55	45.20	38.45	33.90
TWO	22.00	18.70	16.50	35.85	30.50	26.90
THREE	18.85	16.05	14.15	32.70	27.80	24.55
FOUR	17.30	14.75	13.00	31.15	26.50	23.40
FIVE	16.35	13.90	12.30	30.20	25.70	22.65
SIX	15.75	13.40	11.85	29.60	25.20	22.20
SEVEN+	13.85	11.80	10.40	27.70	23.55	20.80

	LEVEL C			LEVEL D		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	66.50	56.55	49.90	89.10	75.75	66.85
TWO	57.15	48.60	42.90	79.75	67.80	59.85
THREE	54.00	45.90	40.50	76.60	65.15	57.45
FOUR	52.45	44.60	39.35	75.05	63.80	56.30
FIVE	51.50	43.80	38.65	74.10	63.00	55.60
SIX	50.90	43.30	38.20	73.50	62.50	55.15
SEVEN+	49.00	41.65	36.75	71.60	60.90	53.70

FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A NURSING HOME, HOSPITAL, INSTITUTION OR HOME

	BRIEF			STANDARD		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	24.00	20.40	18.00	33.50	28.50	25.15
TWO	16.25	13.85	12.20	24.75	21.05	18.60
THREE	13.70	11.65	10.30	21.85	18.60	16.40
FOUR	12.40	10.55	9.30	20.40	17.35	15.30
FIVE	11.60	9.90	8.70	19.50	16.60	14.65
SIX	11.10	9.45	8.35	18.95	16.15	14.25
SEVEN+	9.20	7.85	6.90	16.70	14.20	12.55

	LONG			PROLONGED		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	51.00	43.35	38.25	73.00	62.05	54.75
TWO	43.25	36.80	32.45	65.25	55.50	48.95
THREE	40.70	34.60	30.55	62.70	53.30	47.05
FOUR	39.40	33.50	29.55	61.40	52.20	46.05
FIVE	38.60	32.85	28.95	60.60	51.55	45.45
SIX	38.10	32.40	28.60	60.10	51.10	45.10
SEVEN+	36.20	30.80	27.15	58.20	49.50	43.65

GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

EMERGENCY ATTENDANCES - AFTER HOURS

EMERGENCY ATTENDANCE AFTER HOURS
(on not more than 1 patient on 1 occasion)

\+ 1 — Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday
(See para A.10 of explanatory notes to this Category)
Fee: $58.25 **Benefit:** 75% = $43.70 85% = $49.55

\+ 2 — Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am,*** on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday
(See para A.10 of explanatory notes to this Category)
Fee: $58.25 **Benefit:** 75% = $43.70 85% = $49.55

\+ 601 — Professional attendance, at a place **OTHER THAN CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am***
(See para A.10 of explanatory notes to this Category)
Fee: $69.65 **Benefit:** 75% = $52.25 85% = $59.25

\+ 602 — Professional attendance, **AT CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am***
(See para A.10 of explanatory notes to this Category)
Fee: $69.65 **Benefit:** 75% = $52.25 85% = $59.25

SUBGROUP 2 - GENERAL PRACTITIONER ATTENDANCES

GENERAL PRACTITIONER ATTENDANCES

LEVEL 'A'
Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management

\+ 3 — **SURGERY CONSULTATION**
(Professional attendance at consulting rooms)
Fee: $12.60 **Benefit:** 75% = $9.45 85% = $10.75

\+ 4 — **HOME VISIT**
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) – each patient
Derived Fee: The fee for item 3, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.25 per patient

\+ 13 — **CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR NURSING HOME**
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient
(See para A.6 of explanatory notes to this Category)
Derived Fee: The fee for item 3, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.25 per patient

\+ 19 — **CONSULTATION AT A HOSPITAL**
(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient
(See para A.7 of explanatory notes to this Category)
Derived Fee: The fee for item 3, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.25 per patient

CONSULTATION AT A NURSING HOME
(Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a selfcontained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a selfcontained unit) on 1 occasion) each patient
(See para A.8 of explanatory notes to this Category)

\+ 20 **Derived Fee:** The fee for item 3, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.25 per patient

LEVEL 'B'
Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies

SURGERY CONSULTATION

\+ 23 (Professional attendance at consulting rooms)
Fee: $26.45 **Benefit:** 75% = $19.85 85% = $22.50

HOME VISIT
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) – each patient

\+ 24 **Derived Fee:** The fee for item 23, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.25 per patient

CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR NURSING HOME
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient
(See para A.6 of explanatory notes to this Category)

\+ 25 **Derived Fee:** The fee for item 23, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.25 per patient

CONSULTATION AT A HOSPITAL
(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient
(See para A.7 of explanatory notes to this Category)

\+ 33 **Derived Fee:** The fee for item 23, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.25 per patient

CONSULTATION AT A NURSING HOME
(Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a selfcontained unit) on 1 occasion) - each patient
(See para A.8 of explanatory notes to this Category)

\+ 35 **Derived Fee:** The fee for item 23, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.25 per patient

LEVEL 'C'
Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies

SURGERY CONSULTATION

\+ 36 (Professional attendance at consulting rooms)
Fee: $47.75 **Benefit:** 75% = $35.85 85% = $40.60

HOME VISIT
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) – each patient

\+ 37 **Derived Fee:** The fee for item 36, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.25 per patient

CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR NURSING HOME
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient
(See para A.6 of explanatory notes to this Category)

\+ 38 **Derived Fee:** The fee for item 36, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.25 per patient

+ 40	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.25 per patient
+ 43	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a selfcontained unit) on 1 occasion) - each patient *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.25 per patient
+ 44	**LEVEL 'D'** Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan **SURGERY CONSULTATION** (Professional attendance at consulting rooms) **Fee:** $70.35 **Benefit:** 75% = $52.80 85% = $59.80
+ 47	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) – each patient **Derived Fee:** The fee for item 44, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.25 per patient
+ 48	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.25 per patient
+ 50	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.25 per patient
+ 51	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a selfcontained unit) on 1 occasion) - each patient *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.25 per patient

GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PROLONGED PROFESSIONAL ATTENDANCES

(Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients)

	For a period of not less than 1 hour but less than 2 hours		
+ 160	*(See para A.12 of explanatory notes to this Category)* **Fee:** $160.70	**Benefit:** 75% = $120.55	85% = $136.60
	For a period of not less than 2 hours but less than 3 hours		
+ 161	*(See para A.12 of explanatory notes to this Category)* **Fee:** $267.85	**Benefit:** 75% = $200.90	85% = $227.70
	For a period of not less than 3 hours but less than 4 hours		
+ 162	*(See para A.12 of explanatory notes to this Category)* **Fee:** $375.00	**Benefit:** 75% = $281.25	85% = $324.10
	For a period of not less than 4 hours but less than 5 hours		
+ 163	*(See para A.12 of explanatory notes to this Category)* **Fee:** $482.15	**Benefit:** 75% = $361.65	85% = $431.25
	For a period of 5 hours or more		
+ 164	*(See para A.12 of explanatory notes to this Category)* **Fee:** $535.80	**Benefit:** 75% = $401.85	85% = $484.90

GROUP A7 - ACUPUNCTURE

Professional attendance by a general practitioner **at a place other than a hospital**, involving either:

(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR**

(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies

AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

+ 193	*(See para A.14 of explanatory notes to this Category)* **Fee:** $26.45	**Benefit:** 75% = $19.85	85% = $22.50

Professional attendance by a general practitioner **on 1 or more patients at a hospital**, on one occasion, involving either:

(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR**

(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies

AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

(See para A.14 of explanatory notes to this Category)

+ 195 **Derived Fee:** The fee for item 193, plus $18.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $1.25 per patient

GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES

SUBGROUP 1 - MULTIDISCIPLINARY CARE PLANS

PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary **COMMUNITY CARE PLAN** for a patient (not being a service associated with a service to which **items 740 to 773** apply) - payable not more than once in any 6 month period

‡ 720	*(See para A.21 of explanatory notes to this Category)* **Fee:** $184.20	**Benefit:** 75% = $138.15	85% = $156.60

‡ 724	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to **REVIEW** a multidisciplinary **COMMUNITY CARE PLAN** or a **DISCHARGE CARE PLAN** prepared by that medical practitioner for a patient claimed under **item 720 or 722** (not being a payment in respect of a service to which **items 740 to 773** apply) - payable not more than once in any 3 month period, and not being an attendance in relation to a patient: (a) in respect of whom, in the preceding 3 months, a payment has been made under **item 720**; or (b) in respect of whom, in the preceding month, a payment has been made under **item 722** *(See para A.21 of explanatory notes to this Category)*		
	Fee: $92.10	**Benefit:** 75% = $69.10	85% = $78.30
‡ 726	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **COMMUNITY CARE PLAN** or to a **REVIEW** of a multidisciplinary **COMMUNITY CARE PLAN** prepared by another provider (not being a payment in respect of a service to which **items 740 to 773** apply) - not being an attendance in relation to a patient in respect of whom, in the preceding 6 months, a payment has been made under **item 720** *(See para A.21 of explanatory notes to this Category)*		
	Fee: $25.85	**Benefit:** 75% = $19.40	85% = $22.00
‡ 728	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **DISCHARGE CARE PLAN** or to a **REVIEW** of a multidisciplinary **DISCHARGE CARE PLAN** prepared by another provider (not being a service associated with a service to which **items 722, 740 to 773** apply) *(See para A.21 of explanatory notes to this Category)*		
	Fee: $25.85	**Benefit:** 75% = $19.40	85% = $22.00
	SUBGROUP 2 - CASE CONFERENCES		
‡ 740	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $71.65	**Benefit:** 75% = $53.75	85% = $60.95
‡ 742	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $107.45	**Benefit:** 75% = $80.60	85% = $91.35
‡ 744	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $143.25	**Benefit:** 75% = $107.45	85% = $121.80
‡ 759	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $51.15	**Benefit:** 75% = $38.40	85% = $43.50
‡ 762	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $81.85	**Benefit:** 75% = $61.40	85% = $69.60
‡ 765	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 728** apply) *(See para A.22 of explanatory notes to this Category)*		
	Fee: $112.55	**Benefit:** 75% = $84.45	85% = $95.70

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 3 - OTOLARYNGOLOGY

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

† 11332 **Fee:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25

GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE

ADMINISTRATION OF ^{153}SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) from either:-
(i) carcinoma of the prostate, where hormonal therapy has failed; or
(ii) carcinoma of the breast, where both hormonal therapy and chemotherapy have failed;
and either:-
(a) the disease is poorly controlled by conventional radiotherapy; or
(b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain

▲ 16018 **Fee:** $1,879.00 **Benefit:** 75% = $1,409.25 85% = $1,828.10

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare)

‡ 30219 **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85

LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes. 17706 = 4B + 2T)

‡ 30223 **Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60

A ‡ + 30332 LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes. 17709 = 5B + 4T) (Assist.)
Fee: $266.80 **Benefit:** 75% = $200.10 85% = $226.80

† 30335 LYMPH NODES of AXILLA, complete excision of, to level I (Anaes. 17713 = 5B + 8T) (Assist.)
Fee: $666.90 **Benefit:** 75% = $500.20 85% = $616.00

† 30336 LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes. 17715 = 5B + 10T) (Assist.)
Fee: $800.35 **Benefit:** 75% = $600.30 85% = $749.45

BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes. 17708 = 5B + 3T)

† 30339 **Fee:** $200.05 **Benefit:** 75% = $150.05 85% = $170.05

† 30340 BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes. 17709 = 5B + 4T) (Assist.)
Fee: $266.80 **Benefit:** 75% = $200.10 85% = $226.80

BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes. 17710 = 5B + 5T) (Assist.)

† 30343 **Fee:** $300.15 **Benefit:** 75% = $225.15 85% = $255.15

† 30344 BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes. 17710 = 5B + 5T)
Fee: $266.80 **Benefit:** 75% = $200.10 85% = $226.80

† 30347	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $500.20 **Benefit:** 75% = $375.15 85% = $449.30
† 30348	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $335.50 **Benefit:** 75% = $251.65 85% = $285.20
† 30351	BREAST (female), total mastectomy (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $566.45 **Benefit:** 75% = $424.85 85% = $515.55
† 30352	BREAST (male), total mastectomy (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $333.50 **Benefit:** 75% = $250.15 85% = $283.50
† 30354	BREAST (female), subcutaneous mastectomy (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $800.35 **Benefit:** 75% = $600.30 85% = $749.45
† 30355	BREAST (male), subcutaneous mastectomy (Anaes. 17711 = 5B + 6T) (Assist.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $400.15 **Benefit:** 75% = $300.15 85% = $349.25
‡ + 30360	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes. 17705 = 3B + 2T) **Fee:** $106.10 **Benefit:** 75% = $79.60 85% = $90.20
30361	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional techniques - but not including imaging (Anaes. 17705 = 3B + 2T) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
30363	BREAST, core biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination (Anaes. 17705 = 3B + 2T) **Fee:** $106.10 **Benefit:** 75% = $79.60 85% = $90.20
‡ + 30364	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital or day-hospital facility, excluding aftercare (Anaes. 17707 = 3B + 4T) **Fee:** $166.70 **Benefit:** 75% = $125.05 85% = $141.70
+ 30366	BREAST, microdochotomy of, for benign or malignant condition (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $333.50 **Benefit:** 75% = $250.15 85% = $283.50
+ 30367	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $266.80 **Benefit:** 75% = $200.10 85% = $226.80
+ 30369	ACCESSORY BREAST TISSUE, excision of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $266.80 **Benefit:** 75% = $200.10 85% = $226.80
+ 30370	INVERTED NIPPLE, surgical eversion of (Anaes. 17707 = 3B + 4T) **Fee:** $199.85 **Benefit:** 75% = $149.90 85% = $169.90
+ 30372	ACCESSORY NIPPLE, excision of (Anaes. 17707 = 3B + 4T) **Fee:** $100.05 **Benefit:** 75% = $75.05 85% = $85.05
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
† 45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $964.25 **Benefit:** 75% = $723.20 85% = $913.35
† 45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $687.15 **Benefit:** 75% = $515.40 85% = $636.25

† 45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon**(Assist.) **Fee:** $518.65 **Benefit:** 75% = $389.00 85% = $467.75
† 45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes. 17721 = 5B + 16T) (Assist.) **Fee:** $1,471.75 **Benefit:** 75% = $1,103.85 85% = $1,420.85
† 45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,048.50 **Benefit:** 75% = $786.40 85% = $997.60
† 45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $790.70 **Benefit:** 75% = $593.05 85% = $739.80
† 45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,409.85 **Benefit:** 75% = $1,057.40 85% = $1,358.95
† 45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $1,063.70 **Benefit:** 75% = $797.80 85% = $1,012.80
† 45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17728 = 12B + 16T) (Assist.) **Fee:** $1,772.20 **Benefit:** 75% = $1,329.15 85% = $1,721.30
† 45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $1,336.75 **Benefit:** 75% = $1,002.60 85% = $1,285.85
† 45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17734 = 14B + 20T) (Assist.) **Fee:** $2,133.55 **Benefit:** 75% = $1,600.20 85% = $2,082.65
† 45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $1,609.80 **Benefit:** 75% = $1,207.35 85% = $1,558.90
† 45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17738 = 16B + 22T) (Assist.) **Fee:** $2,494.85 **Benefit:** 75% = $1,871.15 85% = $2,443.95
† 45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $1,881.80 **Benefit:** 75% = $1,411.35 85% = $1,830.90
† 45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17742 = 18B + 24T) (Assist.) **Fee:** $2,856.20 **Benefit:** 75% = $2,142.15 85% = $2,805.30
† 45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $2,154.85 **Benefit:** 75% = $1,616.15 85% = $2,103.95
† 45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17748 = 20B + 28T) (Assist.) **Fee:** $3,254.10 **Benefit:** 75% = $2,440.60 85% = $3,203.20
† 45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon**(Assist.) **Fee:** $2,455.30 **Benefit:** 75% = $1,841.50 85% = $2,404.40
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
† 45496	FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes. 17713 = 5B + 8T) **Fee:** $320.00 **Benefit:** 75% = $240.00 85% = $272.00

† 45497	FLAP, free tissue transfer using microvascular techniques - ***complete revision of***, by liposuction (Anaes. 17709 = 5B + 4T) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
† 45498	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - first stage (Anaes. 17708 = 5B + 3T) **Fee:** $201.20 **Benefit:** 75% = $150.90 85% = $171.05
† 45499	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - second stage (Anaes. 17708 = 5B + 3T) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
	SUBGROUP 15 – ORTHOPAEDIC
† 49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $706.95 **Benefit:** 75% = $530.25 85% = $656.05
‡ 49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes. 17708 = 3B + 5T)(Assist.) **Fee:** $362.10 **Benefit:** 75% = $271.60 85% = $311.20
‡ 49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes. 17710 = 3B + 7T)(Assist.) **Fee:** $633.75 **Benefit:** 75% = $475.35 85% = $582.85
† 49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed – unilateral (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $497.95 **Benefit:** 75% = $373.50 85% = $447.05
† 49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed – bilateral (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $860.00 **Benefit:** 75% = $645.00 85% = $809.10
	GROUP I1 - ULTRASOUND
	SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL
‡ 55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
‡ 55721	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75

‡ 55728	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) it can be demonstrated that a clinical condition other than a condition mentioned in paragraph (f) of item 55718 or paragraph (e) of item 55723 is present (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
* 56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
* 56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.40
	PATHOLOGY SERVICES **GROUP P1 – HAEMATOLOGY**
‡ + 65132	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - where any request for the test by a medical practitioner specifically identifies in writing a history of venous thromboembolism or arterial thrombosis - quantitation by 1 or more techniques - 1 test **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
† 65133	2 tests described in item 65132 **Fee:** $48.00 **Benefit:** 75% = $36.00 85% = $40.80
† 65134	3 tests described in item 65132 **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35
† 65135	4 tests described in item 65132 **Fee:** $94.00 **Benefit:** 75% = $70.50 85% = $79.90
† 65136	5 tests described in item 65132 **Fee:** $117.00 **Benefit:** 75% = $87.75 85% = $99.45
† 65137	Test for the presence of lupus anticoagulant not being a service associated with a service to which item 65132 applies **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
† 65139	Quantitation of plasminogen - 1 test **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
† 65140	Quantitation of euglobulin clot lysis time - 1 test **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
† 65142	Confirmation or characterisation of an abnormal or an indeterminate result using a separate specimen collected on a different day using tests described in item 65132 - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
† 65168	Characterisation of the genotype of a patient for Factor V Leiden gene mutation or detection of other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $36.00 **Benefit:** 75% = $27.00 85% = $30.60
† 65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25

† 65174	Characterisation of the genotype of a person who is a first degree relative of a person who has been proven to have one or more of the abnormal genotypes under item 65168 - 1 or more tests **Fee:** $36.00	**Benefit:** 75% = $27.00	85% = $30.60
	GROUP P2 - CHEMICAL		
‡ + 66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes the following: (a) administration of glucose; (b) at least 2 measurements of blood glucose; and if performed (c) any test described in item 66695 **Fee:** $18.70	**Benefit:** 75% = $14.05	85% = $15.90
	GROUP P3 - MICROBIOLOGY		
‡ 69324	Microscopy with appropriate stains and culture of 1 specimen of sputum, urine, other body fluids or operative or biopsy specimens for mycobacteria including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service described in item 69300 **Fee:** $42.00	**Benefit:** 75% = $31.50	85% = $35.70
‡ 69336	Microscopy of faeces for parasites using concentration techniques (including the use of appropriate stains) with a maximum of 3 examinations on specimens collected on separate days in any 7 day period, including (if performed) a service described in item 69300 - 1 examination **Fee:** $18.65	**Benefit:** 75% = $14.00	85% = $15.90
	GROUP P6 - CYTOLOGY		
‡ 73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues **Fee:** $65.00	**Benefit:** 75% = $48.75	85% = $55.25
‡ 73051	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist; or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance **Fee:** $163.85	**Benefit:** 75% = $122.90	85% = $139.30

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